2014

Utah Annual Report of
Medicaid & CHIP

STATE FISCAL YEAR 2014
July 2013 - June 2014

UTAH DEPARTMENT OF
HEALTH
MEDICAID

Utah Annual Report of Medicaid & CHIP

State Fiscal Year 2014

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This report can be viewed at: www.health.utah.gov/medicaid

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State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

W. David Patton, Ph.D.
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

December 23, 2014

Dear Fellow Utahn:

It is my privilege to present to you the 2014 Medicaid and CHIP Annual Report of the Utah Department of Health (UDOH). This report includes the Division of Medicaid and Health Financing (Division) activities from July 2013 to June 2014 and offers an extensive look at Medicaid's covered services, those who depend on these services, and what the services cost.

Utah's Medicaid program continuously strives to accomplish its strategic goal to *Transform Medicaid*, as identified by the UDOH Strategic Plan. To achieve this vision, the Plan states: "Utah Medicaid will be a respected innovator in employing health care delivery and payment reforms that improve the health of Medicaid clients and keep expenditure growth at a sustainable level." This past year has been met with significant changes in this effort of transformation and innovation:

- The Division's Medicaid Management Information System (MMIS) replacement project successfully implemented the first two releases (of four) as part of the agency's multi-year effort to replace the 30-year-old legacy mainframe system. The new MMIS has been branded, Provider Reimbursement Information System for Medicaid (PRISM).
- To improve operational efficiencies, the Division created and mailed new wallet-sized plastic medical cards for Medicaid members. Instead of being mailed monthly, the new card is sent to the member once and will be used whenever the member is eligible for Medicaid.
- Medicaid's Accountable Care Organization (ACO) model tracked performance data from its first year of implementation with a focus on providing better health outcomes while controlling costs. Early data indicates that the number of inpatient days for Medicaid enrollees has decreased since the implementation of ACOs.
- Working closely with the Governor's office, the Division developed the Governor's Healthy Utah Plan to address the "coverage gap" and high number of uninsured adults living in the state. Utah received unprecedented flexibility from the federal government and finalized an approvable plan.

While much has been accomplished, Utah Medicaid continues to undertake projects and initiatives aimed at increasing efficiency and decreasing costs in order to provide health care services to Utah's most vulnerable populations. UDOH and the Division look forward to the continued cooperation with the Governor's Office, the Utah State Legislature, the Medicaid provider community, and the citizens.

Sincerely,

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

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HEALTH CARE REFORM

- Developed the Governor's Healthy Utah Plan, which involved weekly discussions with the Centers for Medicare and Medicaid Services (CMS) to finalize an approvable plan to cover adults below 133 percent of the Federal Poverty Level (FPL).
- Worked with the Department of Workforce Services (DWS) to implement significant changes to eligibility policy and the eligibility system to meet the Affordable Care Act's (ACA) new Modified Adjusted Gross Income (MAGI)-based eligibility requirements.
- Convened a large stakeholder group and developed the Utah Health Innovation Plan, using funding from the State Innovation Models Design grant.
- Hosted, in conjunction with other divisions from the Utah Department of Health (DOH), the Governor's Health Summit which focused on Medicaid Expansion Options and Utah's Health Innovation Plan.
- Convened and staffed the Medicaid Expansion Options Community Workgroup, which submitted an options report to Governor Herbert at his annual Health Summit. The Workgroup prepared and presented nine Medicaid expansion options for the Governor's consideration.
- Managed the transition of 18,000 children from the Children's Health Insurance Program (CHIP) to Medicaid in compliance with the ACA.
- Managed the transition of 3,900 Primary Care Network (PCN) recipients with incomes over 100 percent FPL to the Federally Facilitated Marketplace for private insurance.

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) REPLACEMENT

- Completed the requirements validation sessions, received a positive CMS review of the project status and the management processes (Onsite Visit December 2013), and successfully implemented Release 1 (new Medicaid website and eligibility lookup tool) on schedule as part of the Division's effort to replace the 30-year-old legacy mainframe system.
- Named and branded the new MMIS as the Provider Reimbursement Information System for Medicaid (PRISM).
- Created and mailed new medical cards for Medicaid members. The new wallet-sized plastic card replaced the former color-coded, full sheet of paper that showed the member's eligibility and was mailed each month. The new card is mailed once and used by the member whenever they are eligible for Medicaid. Providers now use the new Eligibility Lookup Tool to confirm Medicaid enrollment before the patient receives services.
- Implemented a new Medicaid card phone line so that members can call to confirm their eligibility, in conjunction with the new medical card which no longer displays eligibility information and is not mailed each month.

NEW WAIVERS AND PROGRAMS

- Implemented managed care for dental services for pregnant women and children in Weber, Davis, Salt Lake and Utah counties. This included creation of a new 1915(b) waiver.
- Received federal authorization for the Autism Waiver to become an ongoing Medicaid program. The waiver will annually serve approximately 290 children statewide, ages two through six.
- Released a Request for Proposal for the Hemophilia Disease Management Program.
- Implemented a Long Term Care Insurance Partnership provision for Senate Bill 14 (2014), which directed the Department to amend the state Medicaid plan to create a qualified long-term care insurance partnership as defined by federal law.
- Organized a community outreach group to help locate and enroll former foster care children. The ACA allows young adults who were in foster care when they turned age 18 or older eligible to receive Medicaid services up to age 26.
- Created a new Medicaid coverage group for children placed by the Department of Human Services (DHS) in Kinship/Guardianship homes as an alternative to foster care placements.

CUSTOMER SERVICE

- Provided program and plan education to 116,934 Medicaid recipients and 16,507 CHIP recipients.
- Received 83,446 calls in the Health Program Representative Unit.
- Answered more than 290,371 calls from Medicaid clients and providers by Medicaid customer service representatives.
- Processed 6.2 million claims.
- Received 768,730 calls through AccessNow, an automated eligibility line for providers to verify if their patients are enrolled in Medicaid.
- Enrolled 4,303 new providers (full enrollment); enrolled 1,147 providers with limited enrollment; and re-credentialed 1,200 providers.

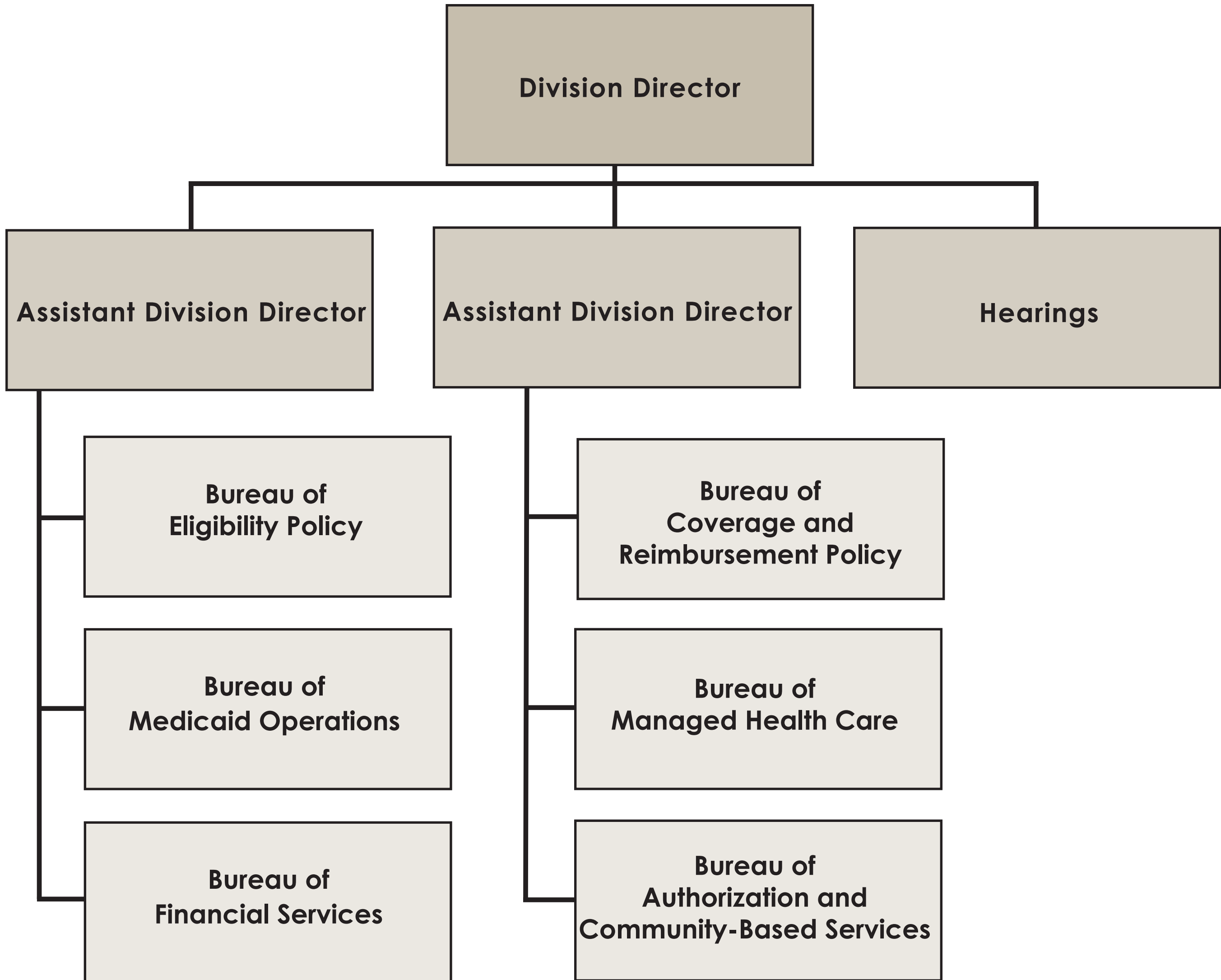
SERVICE DELIVERY AND PAYMENT

- Applied CMS's approved enhanced match rate for children to Medicaid based on the number of children that moved from CHIP to Medicaid.
- Tracked performance data from the first year of implementation of Medicaid's Accountable Care Organization (ACO) model, in which the ACOs are beginning to implement innovative reimbursement models that focus on providing better health outcomes while helping to control costs. For example, early data indicates that the number of inpatient days for Medicaid enrollees has decreased since the implementation of ACOs. ACOs are also working on innovative contracts with their provider networks. These innovative arrangements are intended to treat providers as partners in shared responsibility and accountability for quality care and cost control, while also allowing providers to share in some of the benefits of cost savings.
- Worked with the contracted actuaries to develop capitation rates for the ACOs for January 2014 and July 2014.
- Renewed the Drug Regimen Review contract for services related to the Drug Utilization Review (DUR) Board. Ten DUR Board meetings were held in the year.
- Renewed the Drug Information Services contract in support of the Pharmacy & Therapeutics (P&T) Committee. Eleven P&T meetings were held in the year.
- Prepared and released the Federal Drug Utilization Review report and the state Drug Utilization Review report.
- Updated the pharmaceutical quarterly pricing and state maximum allowable cost (SMAC).
- Worked with contracted actuaries to set certified rates for the 11 contracted mental health and substance use disorder centers.
- Obtained actuarial certification and CMS approval for dental managed care rates and managed care Healthy Outcomes, Medical Excellence (H.O.M.E.) rates.
- Received a five-year renewal and approval from CMS for the Waiver for Individuals with Acquired Brain Injuries.
- Modified the Emergency Only Program and, as a result of that work, now use an episode of care review process for these claims.
- Added 11 new classes to the Preferred Drug List (PDL), now totaling 96 classes on the PDL. These drug class additions, combined with savings from existing PDL classes are expected to generate annualized PDL savings of approximately $48.1 million in total funds ($14.1 million in General Fund).

Mission Statement

The mission of the Division of Medicaid and Health Financing
is to provide access to quality, cost effective health care for eligible Utahns.

Organizational Chart



Division Overview

The Utah Department of Health (DOH), Division of Medicaid and Health Financing (DMHF) administers Medicaid and the Children's Health Insurance Program (CHIP) to provide medical, dental and behavioral health services to needy individuals and families throughout the state. DOH is designated as Utah's Single State Agency for Medicaid.

The administration of Medicaid and CHIP is accomplished through the office of the Division Director and six bureaus. The Division Director administers and coordinates the program responsibilities delegated to develop, maintain and administer the Medicaid program in compliance with Title XIX of the Social Security Act and CHIP in compliance with Title XXI of the Act, the laws of the state of Utah, and the appropriate budget. The Director's Office manages and coordinates staff training and development, legacy MMIS projects, SharePoint workflows, security policies and procedures, as well as Affordable Care Act (ACA) reform initiatives. In addition, each bureau has the following responsibilities:

BUREAU OF FINANCIAL SERVICES

The objectives and responsibilities of this bureau include monitoring, coordinating and facilitating the Division's efforts to operate economical and cost-effective medical assistance programs. The bureau is responsible for coordinating and monitoring federally mandated financial control systems, including monitoring of the Medicaid, CHIP, Utah's Premium Partnership for Health Insurance (UPP), and Primary Care Network (PCN) programs, providers, and all third-party liability (TPL) activity. The bureau also performs budget forecasting and preparation, development of appropriation requests and legislative presentations, monitoring of medical assistance programs, and administration of expenditures and federal reporting.

BUREAU OF MANAGED HEALTH CARE

The primary responsibility of this bureau is to administer all managed care federal waivers and contracts for both Medicaid and CHIP. In addition, the bureau is responsible for staff that provides education and assistance to Medicaid and CHIP beneficiaries regarding selection of managed care plans and appropriate use of Medicaid and CHIP benefits. In addition this bureau monitors the performance of and the quality of services provided by managed care organizations on behalf of Medicaid and CHIP. Managed care includes physical, mental and dental health services. In addition, the bureau is responsible for the oversight of the state's 1115 Primary Care Network Demonstration Waiver, the early periodic screening, diagnosis, and treatment (EPSDT) program that provides well-child health care, the Medicaid restriction program, and the School Based Skills Development program. The bureau director also serves as the state CHIP Director.

BUREAU OF AUTHORIZATION AND COMMUNITY-BASED SERVICES

The general responsibilities of this bureau include policy formulation, interpretation and implementation planning of quality, cost-effective long-term care services that meet the needs and preferences of Utah's low-income citizens. In addition, the bureau is responsible for prior authorizations of Medicaid services not provided by managed care organizations on behalf of Medicaid and CHIP.

BUREAU OF MEDICAID OPERATIONS

This bureau's main objectives are to oversee the accurate and expeditious processing of claims submitted for covered services on behalf of eligible beneficiaries and the training of providers regarding allowable Medicaid expenditures and billing practices. The general responsibilities include processing and adjudication of medical claims; publishing all provider manuals; and serving as the primary point of telephone contact for information about client eligibility, claims processing, and general questions about the Medicaid program.

BUREAU OF COVERAGE AND REIMBURSEMENT POLICY

The general responsibilities of this bureau include benefit policy formulation, interpretation, and implementation planning. This responsibility encompasses scope of service and reimbursement policy for Utah's Medicaid program. The bureau also oversees the pharmacy program, drug utilization review, the Preferred Drug List, and maintains the State Plan.

BUREAU OF ELIGIBILITY POLICY

The primary responsibility of this bureau is to oversee eligibility determinations for Medicaid and CHIP. This includes: interpreting federal or state regulations and writing medical eligibility policy; providing timely disability decisions based on Social Security Disability criteria; monitoring the accuracy and timeliness of Medicaid and CHIP eligibility decisions by reviewing eligibility determinations under guidance from the Centers for Medicare and Medicaid Services (CMS); purchasing private health insurance plans for Medicaid recipients who are at high risk, which saves Medicaid program dollars; and monitoring for program accuracy.

Division Expenditures

Figure 1 shows a breakdown of DMHF state fiscal year (SFY) 2014 expenditures. Medicaid mandatory and optional services comprise 92.2 percent of total expenditures, Medicaid administrative services account for 4.8 percent and CHIP administration and services for 3.0 percent.

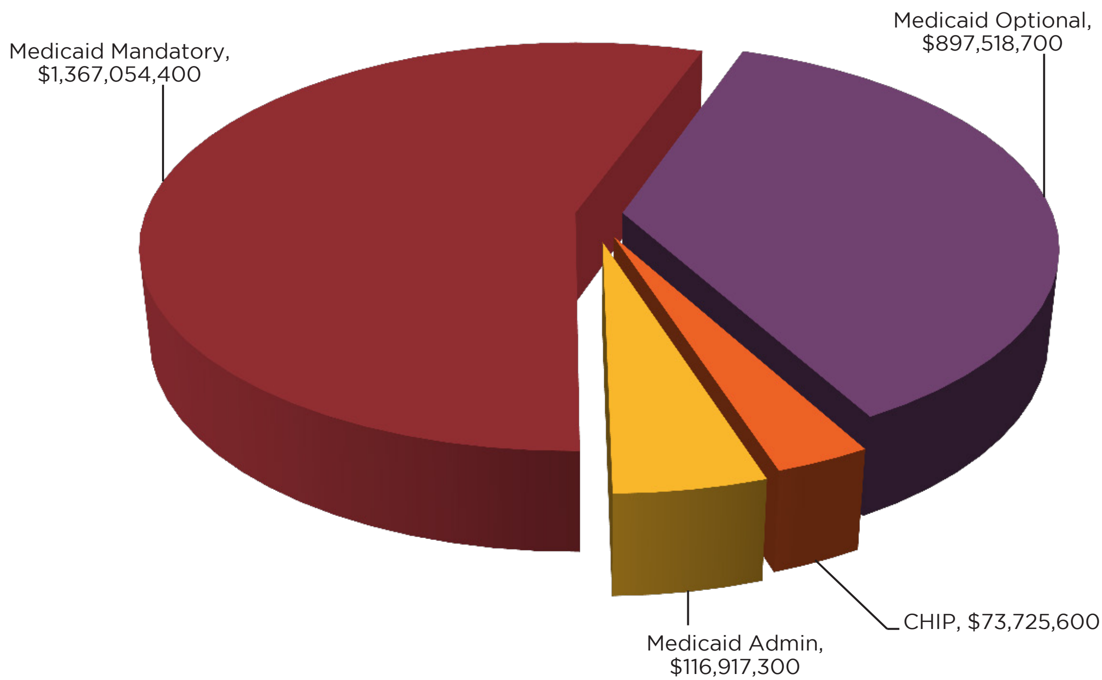


FIGURE 1

Table 1 breaks down the categories in Figure 1 by expenditure types. Approximately 98 percent of the DMHF expenditures are for pass-through charges. Specifically, pass-through charges are incurred for the provision of physical health, behavioral health, dental health and vision care services provided through contracted entities and administrative services provided by other state agencies. Personnel services account for one percent of total expenditures. Table 1 provides a break out of these expenditures for state fiscal years (SFY) 2010 to 2014.

Table 1: Division of Medicaid and Health Financing Expenditures SFY 2010 - SFY 2014

Category	Expenditure Type	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Medicaid Admin	Capital Expenditure	$0	$0	$0	$32,000	$0
	Current Expense	$6,336,200	$4,202,400	$6,132,600	$4,824,900	$4,586,000
	Data Processing Capital Expenditure	$0	$834,700	$309,600	$1,086,500	$0
	Data Processing Current Expense	$7,589,100	$7,483,400	$7,799,800	$8,737,900	$10,374,700
	Other Charges/Pass Through	$70,078,300	$77,942,600	$67,512,400	$68,543,700	$85,538,700
	Personnel Services	$16,255,300	$13,814,300	$14,268,100	$15,034,000	$16,357,100
	Travel/In State	$32,000	$20,500	$23,700	$24,100	$21,300
	Travel/Out of State	$16,000	$21,600	$28,900	$30,400	$39,500
Admin Total		**$100,306,900**	**$104,319,500**	**$96,075,100**	**$98,313,500**	**$116,917,300**
Medicaid Mandatory	Capital Expenditure	$0	$0	$72,000	$22,400	$86,100
	Current Expense	$3,271,100	$2,137,900	$3,154,800	$4,490,100	$4,243,800
	Data Processing Current Expense	$39,700	$63,200	$147,200	$6,133,000	$15,130,800
	Other Charges/Pass Through	$968,318,100	$1,020,253,000	$1,048,141,200	$1,152,586,900	$1,339,952,000
	Personnel Services	$4,985,300	$5,018,300	$4,273,600	$6,153,400	$7,592,800
	Travel/In State	$28,300	$21,200	$30,600	$27,300	$33,000
	Travel/Out of State	$0	$6,200	$1,500	$19,200	$15,900
	Trust & Agency Disbursements	$0	$0	$87,300	($3,700)	$0
Mandatory Total		**$976,642,500**	**$1,027,499,800**	**$1,055,908,200**	**$1,169,428,600**	**$1,367,054,400**
Medicaid Optional	Current Expense	$17,152,600	$3,400,400	$1,678,900	$2,088,900	$123,000
	Data Processing Current Expense	$2,300	$2,000	$20,400	$2,200	$12,600
	Other Charges/Pass Through	$789,965,200	$837,575,600	$911,658,700	$923,136,700	$897,075,700
	Personnel Services	$114,700	$392,700	$119,600	$308,000	$307,400
	Travel/In State	$800	$0	$0	$1,700	$0
	Travel/Out of State	$1,200	$2,000	$17,200	$19,400	$0
Optional Total		**$807,236,800**	**$841,372,700**	**$913,494,800**	**$925,556,900**	**$897,518,700**
Medicaid Total		**$1,884,186,200**	**$1,973,192,000**	**$2,065,478,100**	**$2,193,299,000**	**$2,381,490,400**
CHIP	Current Expense	$803,600	$253,200	$982,800	$333,000	$199,500
	Data Processing Capital Expenditure	$0	$21,400	$2,200	$26,900	$0
	Data Processing Current Expense	$18,200	$18,300	$43,400	$25,600	$10,400
	Other Charges/Pass Through	$75,145,000	$70,120,400	$71,328,600	$71,330,000	$72,829,600
	Personnel Services	$1,016,100	$924,500	$1,139,200	$996,200	$684,200
	Travel/In State	$6,600	$4,200	$2,700	$2,500	$1,500
	Travel/Out of State	$12,100	$16,100	$11,800	$7,500	$400
CHIP Total		**$77,001,600**	**$71,358,100**	**$73,510,700**	**$72,721,800**	**$73,725,600**
Total Expenditures		**$1,961,187,800**	**$2,044,550,100**	**$2,138,988,800**	**$2,266,020,800**	**$2,455,216,000**

Medicaid Management Information System (MMIS) expenditures are included in the “Medicaid Mandatory” category for all years shown.

The Utah Department of Health (DOH), Division of Medicaid and Health Financing (DMHF) provides Medicaid funding for medical services to needy individuals and families throughout the state of Utah. Medicaid is financed by state and federal resources.

Means of Finance

Medicaid was established by Title XIX of the Social Security Act in 1965. Utah implemented its Medicaid program in 1966 which, at the time, focused on acute and long-term care. DOH is designated as the Single State Agency responsible for making state applications to the federal government for all Medicaid funding and Medicaid-related programs. Medicaid, a partnership program between the federal and state governments, provides coverage for physical health, behavioral health, and dental services, as well as long-term care services. Eligibility for the program is based primarily on income and household size. Program eligibility for aged or disabled Medicaid also considers resource levels.

The Medicaid program is administered under the direction of the Centers for Medicare and Medicaid Services (CMS) within the United States Department of Health and Human Services. CMS sets requirements that include funding, qualification guidelines and quality and extent of medical services. CMS also has the responsibility to provide federal oversight of the program.

Medicaid is funded by a share of both federal and state funds. This percentage of federal versus state funding is based on the Federal Medical Assistance Percentages (FMAP), which are updated every Federal Fiscal Year (FFY). The FFY runs from October 1 to September 30. The FMAP for each state ranges from 50 percent to 73.4 percent of program cost. The funding formula is based on each state's latest three year average per capita income. Table 2 is an eleven year historical list of Utah FMAP running from 2004 to 2014, modified to match the State Fiscal Year (SFY), which runs from July 1 on one year to June 30 of the following year.

Table 2: Federal Medicaid Assistance Percentages (FMAP) for Utah SFY 2004 – SFY 2014

SFY	Federal Percentage	State Percentage
2004	71.60%	28.40%
2005	72.04%	27.96%
2006	71.11%	28.89%
2007	70.30%	29.70%
2008	71.26%	28.74%
2009	70.94%	29.06%
2010	71.44%	28.56%
2011	71.27%	28.73%
2012	71.03%	28.97%
2013	69.96%	30.04%
2014	**70.16%**	**29.84%**

DMHF receives approximately 70 percent of its funding from the federal match and 30 percent from the State General Fund. During fiscal years 2009 – 2011, the federal government provided a temporary increase to the FMAP as specified in the American Recovery and Reinvestment Act (ARRA). Those increases are not specified in Table 2. Medicaid administrative costs are generally matched at 50 percent by federal funds.

Figure 2 is a breakout of Medicaid program expenditures. The largest component, "Other Charges/Pass Through," is largely comprised of payments to providers of Medicaid services.

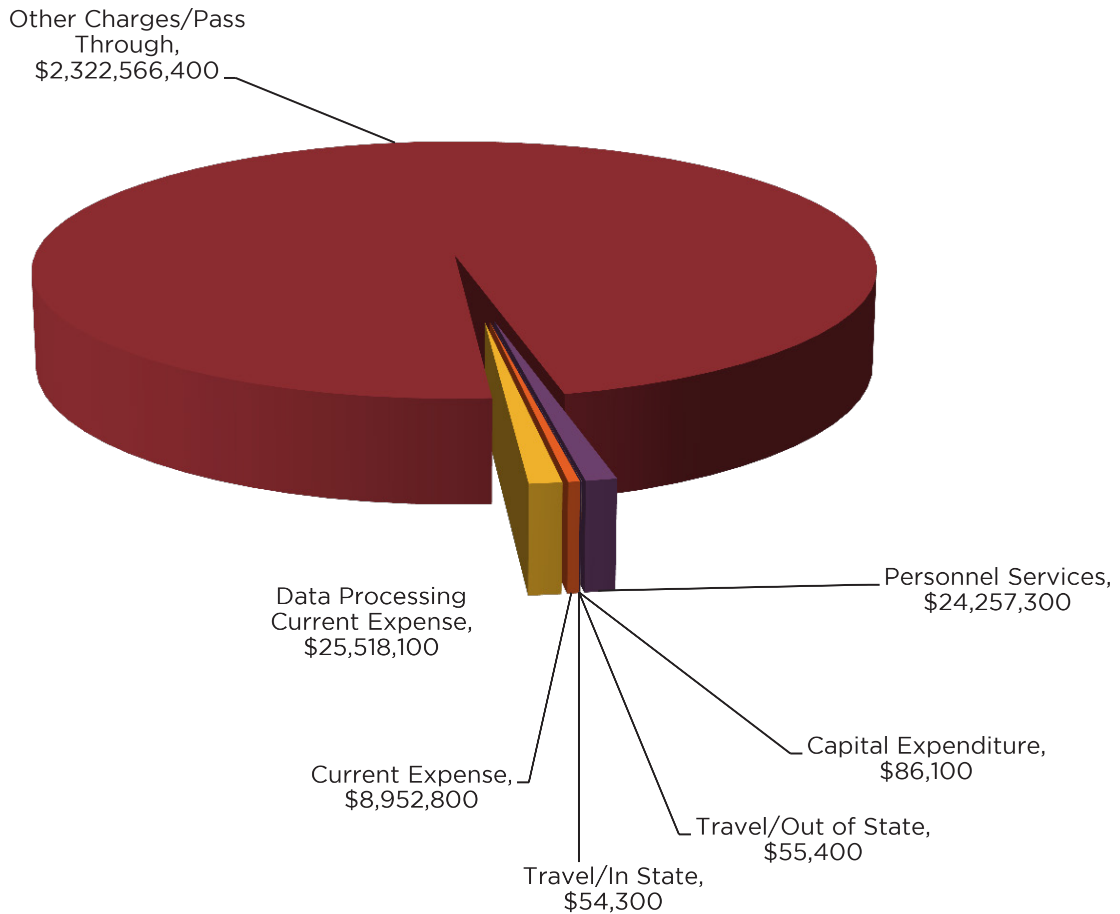


FIGURE 2

Medicaid Finance

DMHF's revenues come from various fund sources, namely the State General Fund, Dedicated Credits, Restricted Revenues, Transfers and the associated Federal Funds. Transfers and most Dedicated Credits are funds from other state agencies, local county agencies, or school districts and are often referred to as "seeded funds", which are used to draw down federal matching funds based on the FMAP. Figure 3 shows a breakout of revenue types, sources and amounts in 2014.

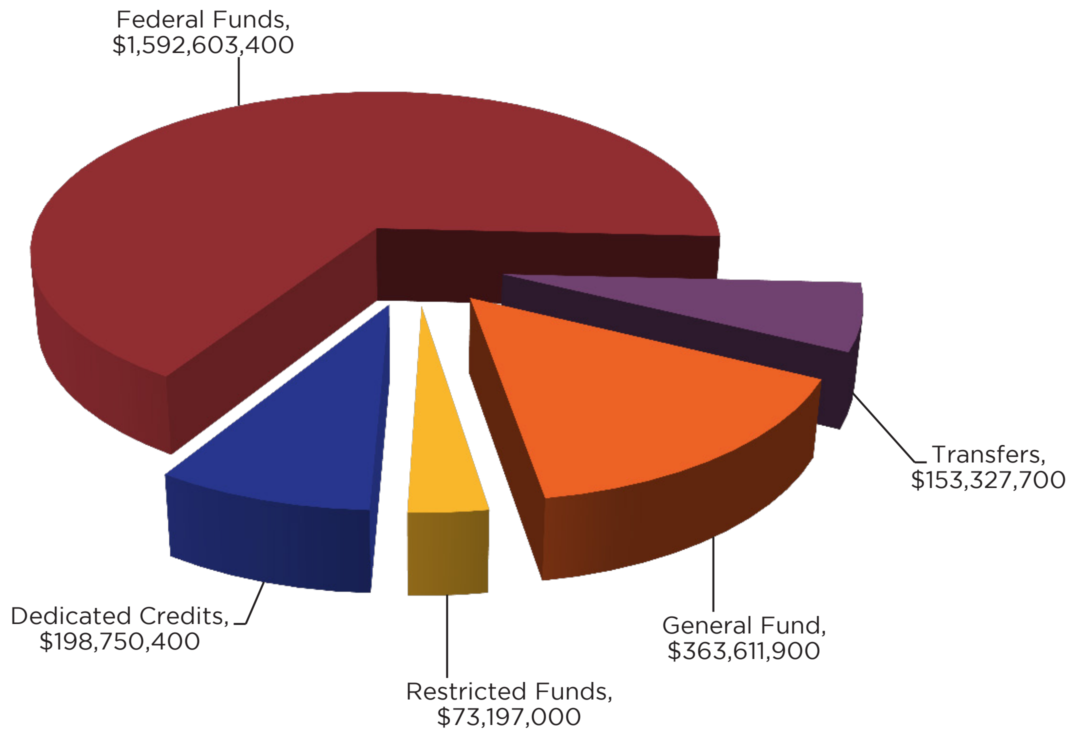
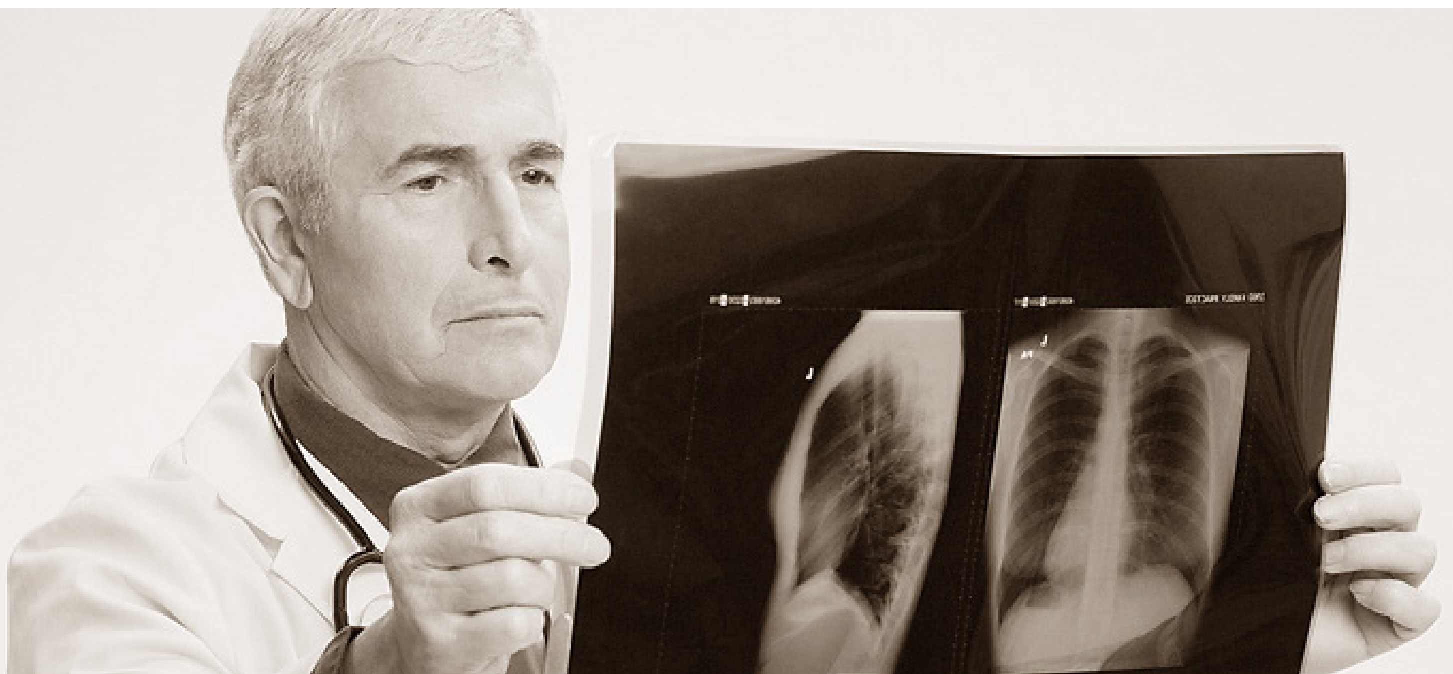


FIGURE 3



Offsets to Medicaid Expenditures

Medicaid expenditures are decreased by means of the following offsets.

CO-PAYMENTS

Medicaid clients are required to pay a portion of the cost for some of the services they receive. For example, clients pay $3 per prescription, up to a maximum of $15 per month.

THIRD PARTY LIABILITY

The Office of Recovery Services (ORS) identifies commercial insurance coverage for Medicaid enrollees. This information is used by the Division to cost avoid Medicaid expenditures. In some circumstances, federal regulations require the state to pay a claim and pursue collection from the third party insurance. ORS is responsible for coordination of benefits for fee-for-service (FFS) Medicaid enrollees. ORS also pursues collection from third parties in personal injury cases involving Medicaid enrollees and for estate recovery in accordance with federal regulations. Managed care organizations are responsible for coordination of benefits for their Medicaid members. These collections are taken into consideration in the rate setting process.

PHARMACY REBATES

Pharmacy retailers offer volume discount rebates to DOH. Pharmaceutical manufacturers pay rebates to DOH. DOH also negotiates supplemental rebates with manufacturers for increased offsets.

SPENDDOWN INCOME

If a potential Medicaid member's income exceeds the eligibility threshold, they have the option to spenddown (or pay part of) their income in order to become eligible for Medicaid.

OTHER COLLECTIONS

The Office of the Attorney General (AG) and the Office of Inspector General of Medicaid Services (OIG) are actively involved in recovering overpayments.

Table 3 reports the Medicaid offsets received in SFY 2014, classified by service category and other sources.

Table 3: Expenditure Offsets SFY 2014 - Actual						
Category Of Service and Other Sources	**Co-Payment**	**Third Party**	**Rebates**	**Spenddown and Other Collections**	**Premiums**	**Total**
Pharmacy	$2,407,600	$6,802,000	$87,646,300	$0	$0	$96,855,900
Inpatient Hospital Srvcs, General	$498,500	$49,427,200	$0	$0	$0	$49,925,700
Outpatient Hospital Srvcs, General	$183,500	$21,038,000	$0	$0	$0	$21,221,500
Physician Services	$266,300	$20,419,400	$0	$0	$0	$20,685,700
Nursing Facility I (NF I)	$0	$16,666,900	$0	$0	$0	$16,666,900
Medical Transportation	$0	$5,846,100	$0	$0	$0	$5,846,100
ESRD Kidney Dialysis Srvcs	$1,200	$5,689,000	$0	$0	$0	$5,690,200
Medical Supply Services	$1,200	$4,885,200	$0	$0	$0	$4,886,400
Home Health Services	$0	$4,372,600	$0	$0	$0	$4,372,600
QMB-Only Services	$3,410,700	$0	$0	$0	$0	$3,410,700
Mental Health Services	$0	$2,024,800	$0	$0	$0	$2,024,800
Osteopathic Services	$67,100	$1,925,400	$0	$0	$0	$1,992,500
Dental Services	$73,100	$675,200	$0	$0	$0	$748,300
Podiatry Services	$4,500	$732,400	$0	$0	$0	$736,900
Independent Lab and/or X-Ray Srvcs	$17,200	$594,000	$0	$0	$0	$611,200
Substance Abuse Treatment Srvcs	$0	$579,300	$0	$0	$0	$579,300
Ambulatory Surgical Services	$1,400	$536,600	$0	$0	$0	$538,000
Specialized Nursing Srvcs	$0	$529,900	$0	$0	$0	$529,900
Psychologist Services	$0	$477,800	$0	$0	$0	$477,800
Physical Therapy Services	$3,300	$459,000	$0	$0	$0	$462,300
Pediatric/Family Nurse Pract	$14,500	$267,500	$0	$0	$0	$282,000
Vision Care Services	$5,700	$261,300	$0	$0	$0	$267,000
Rural Health Clinic Services	$0	$251,500	$0	$0	$0	$251,500
Federally Qualified Health Cntrs	$3,900	$192,000	$0	$0	$0	$195,900
Well Child Care (EPSDT) Srvcs	$0	$105,200	$0	$0	$0	$105,200
USTS IMR-1 Services	$0	$76,500	$0	$0	$0	$76,500
Occupational Therapy	$100	$73,500	$0	$0	$0	$73,600
Inpatient Hospital Srvcs, Mental	$0	$58,700	$0	$0	$0	$58,700
Contracted Mental Hlth Srvcs	$0	$51,800	$0	$0	$0	$51,800
Speech and Hearing Services	$0	$45,600	$0	$0	$0	$45,600
Optical Supply Services	$0	$24,200	$0	$0	$0	$24,200
Nursing Facility III (NF III)	$0	$20,200	$0	$0	$0	$20,200
Specialized Wheel Chairs	$8,200	$0	$0	$0	$0	$8,200
Chiropractic Services	$100	$4,400	$0	$0	$0	$4,500
Aging Waiver Service	$400	$0	$0	$0	$0	$400
ORS Collections	$0	$13,002,700	$0	$13,487,200	$0	$26,489,900
Attorney General/MFCU	$0	$0	$0	$19,608,300	$0	$19,608,300
Recovery Audit Contracts (RAC)	$0	$0	$0	$7,661,400	$0	$7,661,400
Office of Inspector General (OIG)	$0	$0	$0	$752,800	$0	$752,800
Primary Care Network Premiums	$0	$0	$0	$0	$335,500	$335,500
TOTAL	$6,968,500	$158,115,900	$87,646,300	$41,509,700	$335,500	$294,575,900

Medicaid Consolidated Report of Expenditures and Revenues

All Medicaid funds are administered by the Utah Department of Health (DOH). As per federal requirements, all funding for Medicaid must flow through DOH and be governed by a memorandum of understanding for all functions performed by other entities including other state agencies local governments, for profit entities and not-for-profit entities.

As the Medicaid Single State Agency, DOH is ultimately responsible and accountable for all aspects of Medicaid. DOH is required to exercise administrative discretion on the administration and supervision of the Medicaid State Plan, issue policies, rules, and regulations relating to Medicaid program matters.

Programs and services for Medicaid are delivered by DOH, the Departments of Human Services (DHS), and a myriad of contracted providers including University of Utah Medical Center (U of U), local health organizations, not-for-profit entities, and for–profit entities. DOH contracts with the Department of Workforce Services (DWS) to determine eligibility for Medicaid and CHIP. The Utah Office of Inspector General of Medicaid Services (OIG) receives Medicaid funding to audit the Medicaid program as well as identify, investigate, and prosecute Medicaid fraud and abuse. The Office of the Attorney General (AG) also receives funding to provide legal support to DOH, review Medicaid and CHIP contracts and policies, and represents Medicaid and CHIP in administrative and judicial proceeding.

This consolidated report section shows Medicaid funding and the related service expenditures in the following state agencies: DOH, DHS, DWS, U of U, AG, and OIG. The Governor's Office of Management and Budget reviews expenditure data from these six state agencies. In addition, DOH passes funding through to local government and other providers.

Figure 4 illustrates Medicaid funding sources.

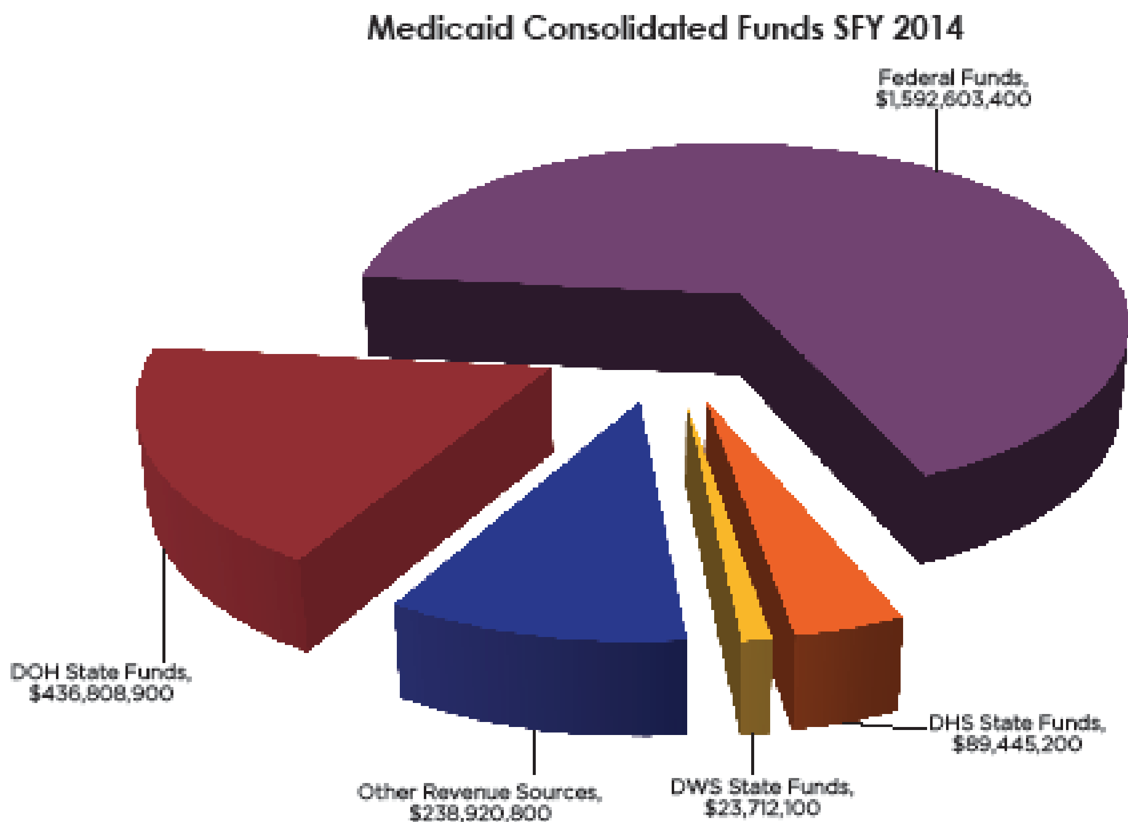


FIGURE 4

Table 4 details the composition of the “Other Revenue Sources in Figure 4.

Table 4: Other Revenue Sources SFY 2014	
Pharmacy Rebates	$87,651,200
Mental Health Services	$48,480,300
Inpatient UPL Payments	$24,672,600
MFCU/OIG	$20,361,100
School Districts	$15,683,100
Physician Enhancement	$12,739,800
Disproportionate Share Hospital	$8,639,200
DHS (Non-Medicaid)	$6,123,600
Substance Abuse	$4,874,700
Family & Health Preparedness	$3,828,100
Healthy U Health Plan	$3,019,800
Health & Dental Clinics	$2,958,100
Nursing Facility NSGO UPL	$2,622,000
Outpatient Hospital UPL	$2,601,900
Refugee Relocation	$1,167,800
Disease Control and Prevention	$1,102,800
CHIP Allocation	$1,054,700
Local Health Departments	$817,300
Inmate Billing	$407,800
PCN Enrollment Fees	$335,500
Early Intervention	$273,800
Center for Health Data	$185,000
Other	$176,600
Total	**$249,776,800**

Table 5 specifies Medicaid funding at the appropriated line item level. Starting in SFY 2014, Medicaid Management Information System (MMIS) replacement funding appropriation unit (LHL) is placed under the mandatory line item.

Table 6 details Medicaid mandatory, optional and administrative expenditures by state agency. Expenditures for the MMIS replacement project are included in DOH mandatory expenditures.

Table 5: Consolidated Medicaid Revenues SFY2014

Mandatory	LHB - Inpatient Hospital	LHC - Nursing Home	LHD - Managed HealthCare	LHE - Physician Services	LHF - Outpatient Hospital	LHG - Other Mandatory Services	LHH - Crossover Services	LHJ - Medical Supplies	LHK - Primary Care Case Management	LHL - Medicaid MIS Replacement	Total
General Fund	$3,322,800	$30,662,500	$190,327,100	$17,703,700	$14,374,300	$12,449,300	$3,476,400	$2,992,800	$0	$24,400	$275,333,300
Federal Funds	$107,651,700	$126,516,100	$582,407,100	$45,323,700	$41,613,100	$31,991,800	$10,031,000	$7,177,400	$0	$16,615,700	$969,327,600
Dedicated Credits	$0	$2,405,100	$23,379,600	$752,800	$55,700	$1,487,800	$0	$0	$0	$0	$28,081,000
Restricted Revenue	$48,500,000	$21,354,100	$0	$0	$0	$41,400	$0	$0	$0	$0	$69,895,500
Pass Through	$13,707,800	$0	$0	$0	$0	$0	$0	$0	$0	$0	$13,707,800
Transfers	($38,398,900)	$1,267,800	$29,000,000	($477,600)	$3,874,300	$6,693,600	$800,000	$96,400	$0	$0	$2,855,600
Beginning Balance	$23,949,600	$0	$0	$0	$0	$0	$0	$0	$0	$3,653,400	$27,603,000
Closing Balance	($14,923,700)	($1,962,500)	($938,300)	($693,600)	($20,500)	($84,100)	($24,500)	($9,200)	$0	($1,093,000)	($19,749,400)
Lapsing Balance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	$143,809,300	$180,243,100	$824,175,500	$62,609,000	$59,896,900	$52,579,800	$14,282,900	$10,257,400	$0	$19,200,500	$1,367,054,400

Optional	LJA - Pharmacy	LJB - Home & Community Based Waivers	LJC - Capitated Mental Health Services	LJD - Buy In/Out	LJE - Dental Services	LJF - Intermediate Care Facilities for Mental Health	LJG - Vision Care	LJH - Other Optional Services	LJK - Non-Service Expenses	LJL - Hospice	LJM, & LJN - DSH & Clawback	Total
General Fund	$31,200	($1,966,700)	$8,500	$15,897,900	$15,116,100	$8,112,000	$455,900	$11,917,000	$0	$2,846,500	$31,713,900	$84,132,300
Federal Funds	$10,786,800	$130,313,800	$98,103,700	$26,067,300	$30,778,000	$59,747,600	$1,047,700	$81,539,500	$77,586,700	$10,185,500	$22,097,400	$548,254,000
Dedicated Credits	$87,651,200	$0	$32,634,600	$0	$0	$0	$0	$13,292,300	$18,184,900	$0	$8,066,700	$159,829,700
Restricted Revenue	$0	$0	$0	$0	$0	$1,654,300	$0	$0	$0	$1,197,000	$0	$2,851,300
Pass Through	$5,902,400	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,902,400
Transfers	($6,920,500)	$53,328,400	$14,046,800	$2,300,000	($1,242,100)	$16,999,900	$49,600	$6,419,000	($1,300,000)	$300,000	$1,277,200	$85,258,300
Beginning Balance	$9,995,200	$4,058,100	$0	$0	$0	$0	$0	$0	$0	$0	$0	$14,053,300
Closing Balance	($14,400)	($4,700)	($26,500)	($8,000)	($366,000)	($3,800)	($300)	($1,900)	($1,587,100)	($20,900)	($729,000)	($2,762,600)
Lapsing Balance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	$107,431,900	$185,728,900	$144,767,100	$44,257,200	$44,286,000	$86,510,000	$1,552,900	$113,165,900	$92,884,500	$14,508,100	$62,426,200	$897,518,700

	Services	Admin	Total
General Fund	$359,465,600	$4,146,300	$363,611,900
Federal Funds	$1,517,581,600	$75,021,800	$1,592,603,400
Dedicated Credits	$187,910,700	$10,839,700	$198,750,400
Restricted Revenue	$72,746,800	$450,200	$73,197,000
Pass Through	$19,610,200	$216,300	$19,826,500
Transfers	$88,113,900	$26,459,400	$114,573,300
Beginning Balance	$41,656,300	$475,000	$42,131,300
Closing Balance	($22,512,000)	($475,000)	($22,987,000)
Lapsing Balance	$0	($216,400)	($216,400)
	$2,264,573,100	**$116,917,300**	**$2,381,490,400**

Table 6: Consolidated Medicaid Expenditures SFY2014

Mandatory	DOH	DHS	U of U	DWS	AG	OIG	Total
Inpatient Hospital	$115,144,900	$0	$28,664,300	$0	$0	$0	$143,809,200
Nursing Home	$180,243,100	$0	$0	$0	$0	$0	$180,243,100
Contracted Health Plan Services	$676,141,600	$0	$148,034,000	$0	$0	$0	$824,175,600
Physician Services	$60,513,500	$0	$2,095,500	$0	$0	$0	$62,609,000
Outpatient Hospital	$47,802,900	$0	$12,094,000	$0	$0	$0	$59,896,900
Other Mandatory Services	$44,585,400	$0	$7,994,400	$0	$0	$0	$52,579,800
Crossovers	$14,282,900	$0	$0	$0	$0	$0	$14,282,900
Medical Supplies	$10,257,400	$0	$0	$0	$0	$0	$10,257,400
Medicaid MIS Replacement	$19,200,500	$0	$0	$0	$0	$0	$19,200,500
Subtotal	$1,168,172,200	$0	$198,882,200	$0	$0	$0	$1,367,054,400
Optional	**DOH**	**DHS**	**U of U**	**DWS**	**AG**	**OIG**	**Total**
Pharmacy	$107,432,100	$0	$0	$0	$0	$0	$107,432,100
Home & Community Based Waivers	$7,430,000	$178,298,900	$0	$0	$0	$0	$185,728,900
Mental Health Services	$144,767,100	$0	$0	$0	$0	$0	$144,767,100
Intermediate Care Facilities	$30,766,900	$55,743,300	$0	$0	$0	$0	$86,510,200
Other Optional Services - HCBS Waiver	$32,339,000	$0	$0	$0	$0	$0	$32,339,000
Other Optional Services (all others)	$80,813,700	$0	$13,000	$0	$0	$0	$80,826,700
Inpatient UPL Payments	$0	$0	$45,993,100	$0	$0	$0	$45,993,100
Buy In / Out	$44,257,200	$0	$0	$0	$0	$0	$44,257,200
Dental Services	$44,286,100	$0	$0	$0	$0	$0	$44,286,100
Disproportionate Share Hospital	$0	$934,600	$30,483,100	$0	$0	$0	$31,417,700
Clawback Payments	$0	$0	$31,008,500	$0	$0	$0	$31,008,500
Non-Service Expenditures	$28,740,500	$0	$0	$0	$0	$0	$28,740,500
Hospice Care Services	$14,508,100	$0	$0	$0	$0	$0	$14,508,100
UUMG Physician Enhancement	$0	$0	$11,997,700	$0	$0	$0	$11,997,700
Graduate Medical Education	$1,540,700	$0	$4,612,300	$0	$0	$0	$6,153,000
Vision Care	$1,487,200	$0	$65,600	$0	$0	$0	$1,552,800
Subtotal	**$538,368,600**	**$234,976,800**	**$124,173,300**	**$0**	**$0**	**$0**	**$897,518,700**
Administrative	**DOH**	**DHS**	**U of U**	**DWS**	**AG**	**OIG**	**Total**
	$47,792,400	**$16,965,800**	**$0**	**$49,716,400**	**$233,200**	**$2,209,500**	**$116,917,300**
Total Expenditures	**DOH**	**DHS**	**U of U**	**DWS**	**AG**	**OIG**	**Total**
	$1,754,333,200	**$251,942,600**	**$323,055,500**	**$49,716,400**	**$233,200**	**$2,209,500**	**$2,381,490,400**

Each agency in state government that participates in Medicaid service delivery has provided the following summary of information.

UTAH DEPARTMENT OF HEALTH - DIVISION OF MEDICAID AND HEALTH FINANCING

The Utah Department of Health (DOH) was created in 1981 to protect the public's health by preventing avoidable illness, injury, disability and premature death; assure access to affordable, quality health care; promote healthy lifestyles; and monitor health trends and events.

Table 7 shows SFY 2014 Medicaid mandatory, optional, and administrative expenditures managed within DOH.

Table 7: Utah Department of Health / Division of Medicaid and Health Financing

Service Expenditures			
Mandatory		*Total Exp*	*Percent of Total*
	Inpatient Hospital	$115,144,900	6.6%
	Nursing Home	$180,243,100	10.3%
	Contracted Health Plan Services	$676,141,600	38.5%
	Physician Services	$60,513,500	3.4%
	Outpatient Hospital	$47,802,900	2.7%
	Other Mandatory Services	$44,585,400	2.5%
	Crossovers	$14,282,900	0.8%
	Medical Supplies	$10,257,400	<1%
	Medicaid MIS Replacement	$19,200,500	1.1%
	Total Mandatory	**$1,168,172,200**	**66.6%**
Optional		*Total Exp*	*Percent of Total*
	Pharmacy	$107,432,100	6.1%
	Home & Community Based Waivers	$7,430,000	0.4%
	Mental Health Services	$144,767,100	8.3%
	Buy In / Out	$44,257,200	2.5%
	Dental Services	$44,286,100	2.5%
	Intermediate Care Facilities	$30,766,900	1.8%
	Vision Care	$1,487,200	<1%
	Other Optional Services	$156,401,300	8.9%
	Graduate Medical Education	$1,540,700	<1%
	Total Optional	**$538,368,600**	30.7%
			0.0%
Total Service Expenditures UDOH/DMHF		**$1,706,540,800**	**97.3%**
Administrative Expenditures			
Responsibilities:			
Claims payment, rate setting, cost settlement, contracting, prior authorization of services, waiver management, client plan selection.			
		Total Exp	*Percent of Total*
	Current Expense	$4,586,000	0.3%
	Data Processing Current Expense	$10,374,700	<1.0%
	Other Charges/Pass Through	$16,647,000	<1.0%
	Personnel Services	$16,123,900	<1.0%
	Travel/In State	$21,300	0.0%
	Travel/Out of State	$39,500	0.0%
Total Admin Expenditures UDOH/DMHF		**$47,792,400**	**2.7%**
Total DOH Medicaid Expenditures		**$1,754,333,200**	**100.0%**
Total UDOH Budget		**$2,670,931,500**	
Medicaid as a % of Overall Budget		**65.7%**	

Medicaid Consolidated Report

DEPARTMENT OF HUMAN SERVICES

The Department of Human Services (DHS), authorized under UCA 62A-1-102, provides direct and contracted social services to persons with disabilities, children and families in crisis, juveniles in the criminal justice system, individuals with mental health or substance abuse issues, vulnerable adults, and the elderly. In addition, DHS is responsible for the administration of the child support services program.

Table 8 shows Medicaid expenditures by DHS by category of service and funding source, as well as administrative costs.

Table 8: Department of Human Services

Service Expenditures - Actual (Through DHS)	*Federal Funds*	*State Funds*	*Total*	*Percent of Total*
People with Disabilities*	$150,317,300	$63,777,700	$214,095,000	85.0%
Utah State Hospital	$14,685,300	$6,196,500	$20,881,800	8.3%
Total Service Expenditures DHS	$165,002,600	$69,974,200	$234,976,800	93.3%
Administrative Expenditures - Actual				
Total Administrative Expenditures DHS	$8,921,600	$8,044,200	$16,965,800	6.7%
TOTAL Expenditures (Through DHS)	$173,924,200	$78,018,400	$251,942,600	100.0%
Service Expenditures - Direct Billed to DOH (State participation from DHS to DOH)				
Child and Family Services		$4,745,000		
Juvenile Justice Services		$1,765,600		
Substance Abuse and Mental Health		$3,713,700		
Aging and Adult Services		$1,202,500		
Total State Funds for Direct Billed Expenditures		$11,426,800		
Total DHS Line Item Expenditures	**$697,784,000**			
Medicaid as a % of Expenditures	**36%**			

*Includes the Utah State Developmental Center

DHS Divisions are as follows:

Executive Director's Operations – provide direction, guidance, and fiscal support. Services include licensing, review, and public guardian.

Division of Substance Abuse and Mental Health (DSAMH) – promotes prevention education, early intervention, residential treatment, and recovery support for individuals who suffer from substance abuse or mental illness. The Utah State Hospital, an entity of DSAMH, provides care specializing in services for individuals with severe and persistent mental illness.

Division of Services for People with Disabilities (DSPD) – provides a wide range of in-home and out-of-home services for people with mental disabilities, physical disabilities, and acquired brain injuries. The Utah State Developmental Center, an entity of DSPD, provides residential care and treatment for people with severe disabilities.

Office of Recovery Services (ORS) – provides child support collection services and third-party Medicaid recovery services.

Division of Child and Family Services – provides child welfare and domestic violence services in partnership with communities, including child abuse prevention; child protective services; in-home services; foster care; adoption; and domestic violence supports, treatment, and shelter.

Division of Aging and Adult Services – promotes a wide variety of home and community-based services for elderly individuals to be protected from abuse, neglect, and exploitation, and to be able to maintain their independence rather than having to reside in nursing facilities.

Division of Juvenile Justice Services – provides services to youth offenders with a comprehensive array of programs including intervention, home detention, secure detention, day reporting centers, case management, community alternatives, observation and assessment, long-term secure facilities, transition, rehabilitation, and youth parole.

DEPARTMENT OF WORKFORCE SERVICES

The Department of Workforce Services (DWS) was created in 1997, per UCA 35A-1-103(1), to provide employment and support services for customers to improve their economic opportunities. Costs of DWS for the Eligibility Services Division are computed by taking a random moment time sample. DWS eligibility workers are sampled and asked to record the time they spent on fourteen public assistance programs. Total costs are allocated on a quarterly basis to the various programs based on the percent of time derived from the sample.

Table 9 shows DWS Medicaid administrative expenditures in SFY 2014 by cost type and funding source.

Table 9: Department of Workforce Services

Administrative Expenditures - Actual	*Federal Funds*	*State Funds*	*Total*	*Percent of Total*
Direct Costs	$34,485,100	$12,773,100	$47,258,200	95.1%
Allocated Costs	$2,375,200	$83,000	$2,458,200	4.9%
Total Admin Expenditures DWS	**$36,860,300**	**$12,856,100**	**$49,716,400**	**100.0%**

Total DWS Line Item Expenditures	**$954,164,300**
Medicaid as a % of Overall Budget	**5.2%**

Divisions and budget areas within DWS are as follows:

Eligibility Services Division - The Eligibility Services Division was created in 2009 to centralize the State's public assistance eligibility process using the state's eligibility system, eREP, to process applications. The Division determines eligibility for the Medicaid, CHIP, and other federal and state public assistance programs.

Eligibility for the different medical programs varies depending upon the program. Some major elements of consideration include citizenship, income level, Utah residency, assets, and the presence of dependents in the home. Generally, those who receive coverage must renew their coverage annually to confirm continued eligibility.

Medical Programs - Medical Programs is a specific budget area at DWS and includes Medicaid, CHIP, PCN, and UPP eligibility. Prior to SFY 2008, DOH conducted about 60 percent of medical determinations, including all of the CHIP and UPP determinations. DWS performed about 40 percent of the determinations. In SFY 2008, the entire eligibility determination component of these programs was transferred from DOH to DWS. General administration and oversight of these programs remains within DOH.

Medical Programs are funded by the General Fund and federal funds for Medicaid, CHIP, PCN and UPP. DWS receives funding to provide eligibility determinations within each of these programs. All payments for medical services are made by DOH.

Medical Programs Performance Measures - DWS performance on behalf of Medicaid and CHIP is measured in several ways. Federal regulation requires that a decision be made on a medical application within 45 days following the date of application and 90 days for Disability Medicaid. However, federal policy allows extensions for the applicant to provide proof of eligibility. DOH has established a timeliness benchmark of 30 days matching other programs that DWS administers, such as Supplemental Nutritional Assistance Program (formerly known as Food Stamps).

OFFICE OF THE ATTORNEY GENERAL

The Division of Child and Family Support, Health Unit, within the Office of the Attorney General (AG) also provides legal support to DOH, reviews Medicaid and CHIP contracts and policies, and represents Medicaid and CHIP in administrative and judicial proceedings. Table 10 shows the AG Medicaid expenditures for SFY 2014.

Table 10: Office of the Attorney General			
Administrative Expenditures - Actual	*Federal Funds*	*State Funds*	*Total*
AG Total Administrative Expenditures	$116,600	$116,600	$233,200

OFFICE OF THE INSPECTOR GENERAL OF MEDICAID SERVICES

The Office of Inspector General of Medicaid Services (OIG) is an independent office of program evaluation and review located within the Department of Administrative Services. The purpose of this office is to ensure adequate internal controls are in place, effective policies and procedures are established and followed in the Medicaid program, and investigate and identify potential or actual fraud, waste, or abuse in the state Medicaid program. Table 11 shows Medicaid administrative expenditures. OIG expenditures are considered 100 percent Medicaid related.

Table 11: Office of Inspector General of Medicaid Services			
Administrative Expenditures - Actual	*Federal Funds*	*State Funds*	*Total*
OIG Total Administrative Expenditures	$1,225,600	$983,900	$2,209,500

UNIVERSITY OF UTAH MEDICAL CENTER

The University of Utah is involved in four Medicaid program areas:

1. **Inpatient Disproportionate Share Hospital** – These funds come from finite federal allocation to states and are used to pay hospitals that serve a disproportionate share of Medicaid and uninsured patients. The funds are intended to offset some of the hospitals costs in serving these clients.

2. **Direct Graduate Medical Education (GME)** – These funds offset some of the costs of residency programs that serve Medicaid clients. The funds cannot be used for academic programs but are used to cover some of the patient care costs associated with the care provided by residents. These funds are subject to the calculated Upper Payment Limit (UPL) authorized by CMS. The non-federal share of GME is provided by DOH.

3. **Inpatient Upper Payment Limit (UPL)** – These funds reimburse the hospital up to the Medicare upper limit. The funds help offset some of the clinical care costs. All of the UPL funds are matched by the University and are subject to the calculated UPL as authorized by CMS.

4. **University of Utah Medical Group (UUMG) Supplemental Payments** – These funds supplement the physician payments up to the average commercial rate. The non-federal share is provided by UUMG to be matched to the extent allowed by CMS.

Table 12 shows where the University of Utah expended Medicaid funds during SFY 2014.

Table 12: University of Utah Medical Center

Service Expenditures - Actual			
Mandatory		*Expenditures*	*Percent of Total*
	Inpatient Services	$28,664,300	8.9%
	Contracted Health Plan	$148,034,000	45.8%
	Physician Services	$2,095,500	0.6%
	Outpatient Hospital	$12,094,000	3.7%
	Other Mandatory Services	$7,994,400	2.5%
	Total Mandatory	**$198,882,200**	**61.6%**
Optional		*Expenditures*	*Percent of Total*
	Vision Care	$65,600	<1.0%
	Disproportionate Share Hospital	$30,483,100	9.4%
	Graduate Medical Education	$4,612,300	1.4%
	Clawback Payments	$31,008,500	9.6%
	Inpatient UPL Payments	$45,993,100	14.2%
	UUMG Physician Enhancement	$11,997,700	3.7%
	Other Optional Services	$13,000	<1.0%
	Total Optional	**$124,173,300**	**38.4%**
U of U Total Service Expenditures		$323,055,500	100%

The enrollment process and eligibility determinations for Medicaid are made primarily by the Department of Workforce Services (DWS), with a limited number completed by the Department of Human Services (DHS). Eligibility requirements for Medicaid are based on Title XIX of the Social Security Act. There are more than 30 types of Medicaid classifications, each with varying eligibility requirements. Household income is a primary consideration for eligibility. Eligibility for some programs is limited by the amount of assets an individual or a household possesses. The Affordable Care Act (ACA) has required that states raise the minimum income level to at least 133 percent of the Federal Poverty Level (FPL), add an income disregard equal to five percentage points of the FPL, and remove the Medicaid asset test for children, pregnant women, and parents effective January 1, 2014. In addition, with the availability of tax credits in the Federally Facilitated Marketplace for individuals with income above 100 percent FPL, income eligibility for the Primary Care Network (PCN) was reduced from 150 percent FPL to 100 percent FPL.

For this report, the Medicaid classifications are summarized in the following aid groups:

- Children (individuals under age 19)
- Parents (adults in families with dependent children)
- Pregnant women
- Individuals with disabilities (individuals determined disabled by the state or the Social Security Administration)
- The elderly (individuals age 65 or older)
- Visually impaired individuals (individuals of any age who meet Social Security's criteria for statutory blindness)
- Women with breast or cervical cancer
- Individuals who participate in a Medicare Cost-Sharing Program
- Primary Care Network (PCN) program (low-income adults who do not meet criteria for any of the above listed groups)

Medicaid serves as the nation's primary source of health insurance coverage for low-income populations. Medicaid provides funding for individuals and families who meet the eligibility criteria established by Utah and approved by the Centers for Medicare and Medicaid Services (CMS). Providers of health care services delivered to Medicaid enrollees are reimbursed by the Division of Medicaid and Health Financing (DMHF).

In order to receive federal funding participation, Utah agrees to cover certain groups of individuals (mandatory groups) and offer a minimum set of services (mandatory services). Through waivers, Utah is also able to receive federal matching funds to cover additional services (optional services), as well as additional qualifying groups of individuals (optional groups).

Each state sets an income limit within federal guidelines for Medicaid eligibility groups and determines what income counts toward that limit. Family size plays a part in the financial qualification for Medicaid. See Appendix A for the 2014 HHS Federal Poverty Levels.

Medicaid enrollment numbers and corresponding expenditures are impacted by economic and demographic factors. The percentage of Utahns living under the FPL influences the level of state reliance on the Medicaid program services. See Appendix A for details.

Medicaid Benefits

Medicaid benefits vary, from person to person, depending on differences in:

- Age
- Pregnancy
- Category of Assistance

Differences in benefits include:

- PCN covers only primary care services
- Individuals who are not pregnant or are not a child may have co-payment or cost-sharing requirements

The Medicaid program is required to provide medical services to "Categorically Needy" individuals. Many categorically needy optional groups and medically needy individuals are covered in Utah as a state option. "Medically Needy" individuals have enough income to meet basic living costs, but are unable to afford vital medical care.

Enrollment Statistics

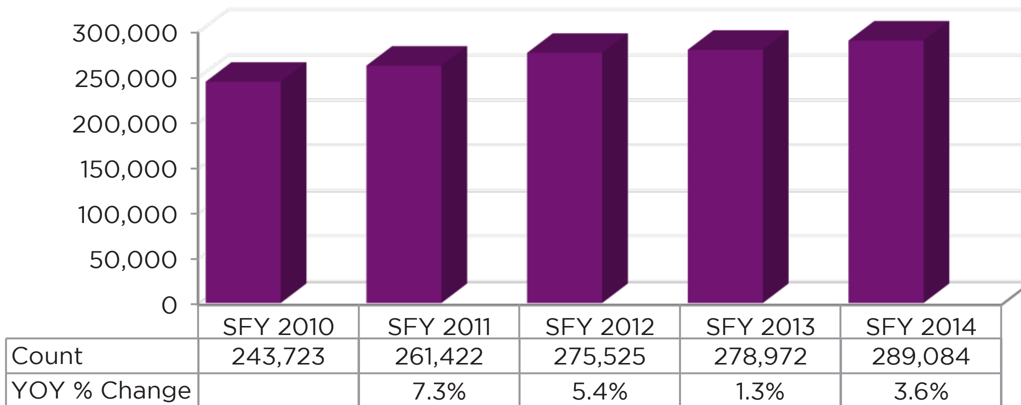
A Medicaid enrollee is defined as an individual who meets the established eligibility criteria of the program, who has applied and has been approved by Medicaid to receive services, regardless of whether the enrollee received any service or any claim has been filed on his or her behalf.

AVERAGE MEMBERS PER MONTH BY CATEGORY OF ASSISTANCE

"Member months" are defined as the number of Medicaid clients enrolled in each month over a fiscal year. Individuals, in this measure, can be counted multiple times depending on the number of months they are eligible to receive Medicaid services. The average members per month (the average monthly enrollment) in a fiscal year is computed by dividing total member months by 12.

Figure 5 shows the average members per month for all categories of assistance combined.

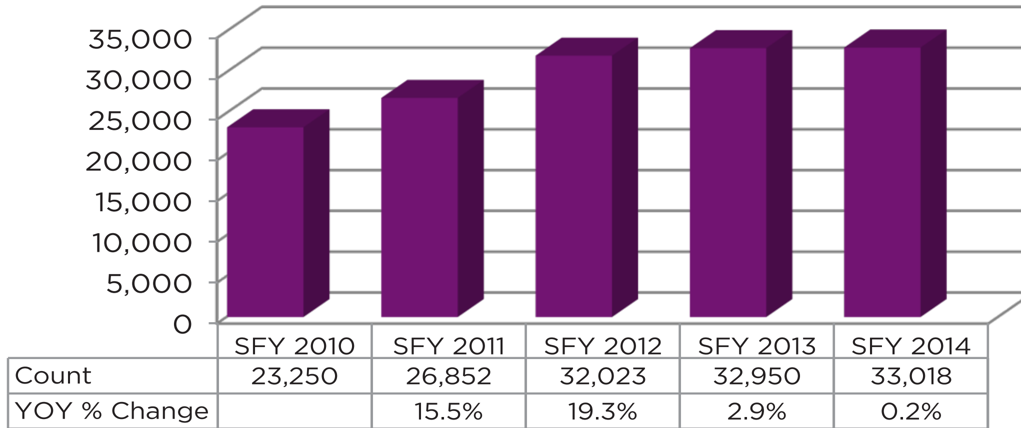
Average Member Months: All Categories



	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Count	243,723	261,422	275,525	278,972	289,084
YOY % Change		7.3%	5.4%	1.3%	3.6%

FIGURE 5

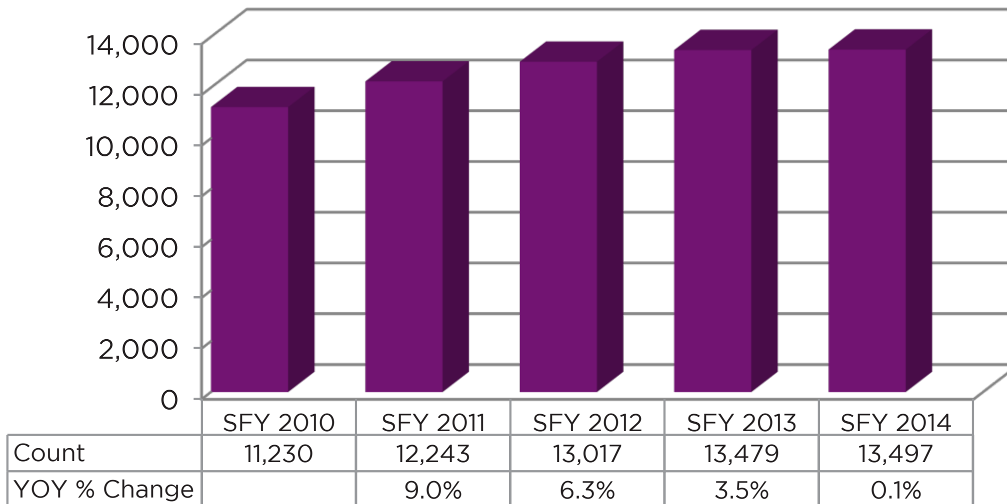
Figure 6 provides a look at average monthly adult enrollees.



	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Count	23,250	26,852	32,023	32,950	33,018
YOY % Change		15.5%	19.3%	2.9%	0.2%

FIGURE 6

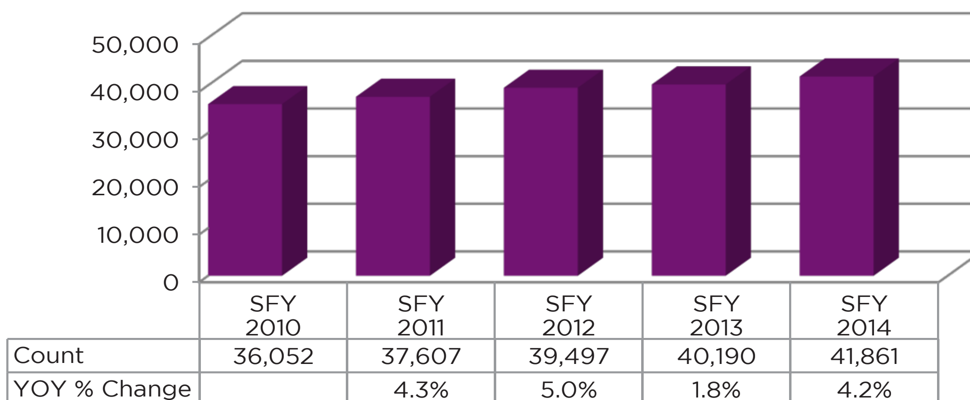
Figure 7 illustrates the average monthly enrollment for individuals age 65 and older.



	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Count	11,230	12,243	13,017	13,479	13,497
YOY % Change		9.0%	6.3%	3.5%	0.1%

FIGURE 7

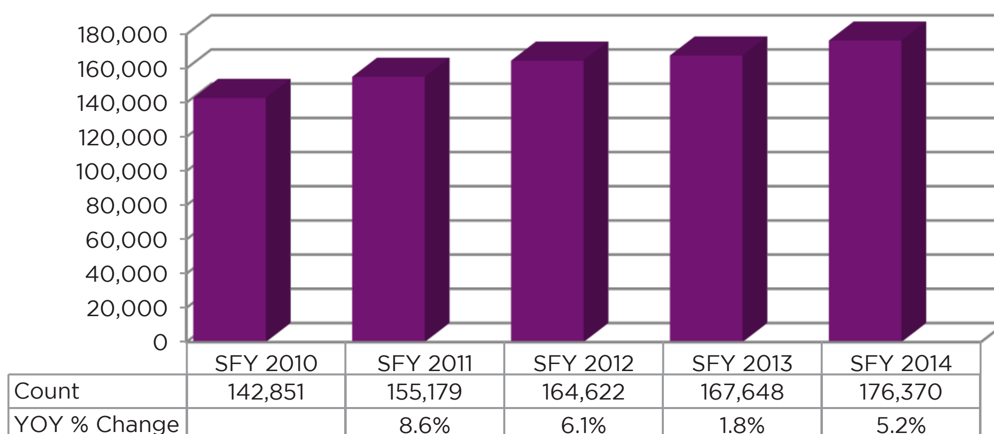
Figure 8 shows average monthly enrollment for the visually impaired and people with disabilities. Please note, due to some adjustments the counts in this year's report, the historical counts for the visually impaired and people with disabilities in this report do not align with those reported in SFY 2013.



	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Count	36,052	37,607	39,497	40,190	41,861
YOY % Change		4.3%	5.0%	1.8%	4.2%

FIGURE 8

Figure 9 depicts the average members per month for Medicaid enrolled children.



	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Count	142,851	155,179	164,622	167,648	176,370
YOY % Change		8.6%	6.1%	1.8%	5.2%

FIGURE 9

Figure 10 portrays the average monthly enrollment of pregnant women.

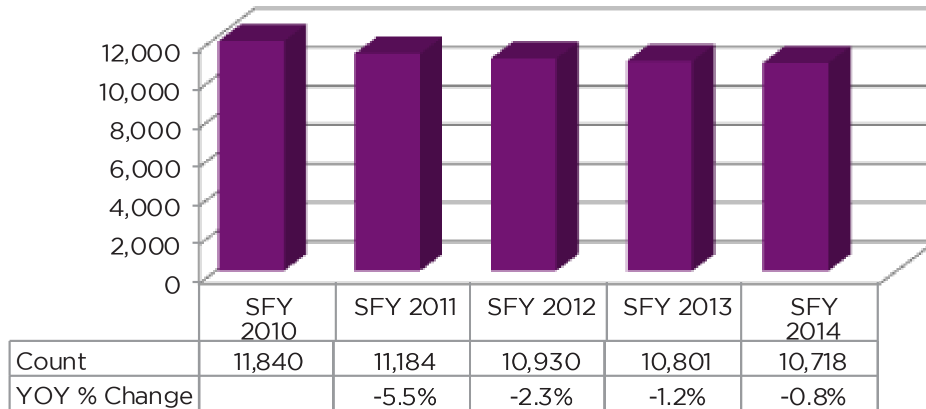


FIGURE 10

Figure 11 show the average members per month for PCN enrollees. Unlike other categories of aid, the number of PCN member months is dependent on the number of open enrollment events.

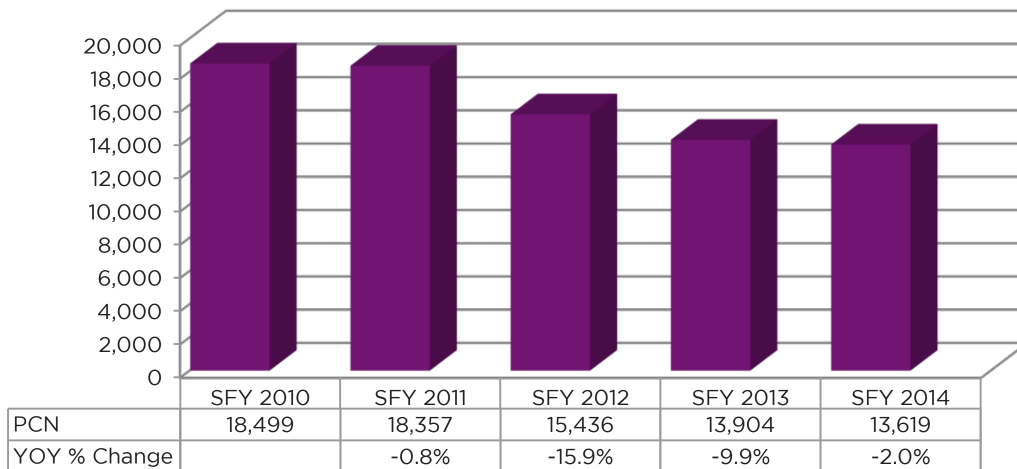


FIGURE 11

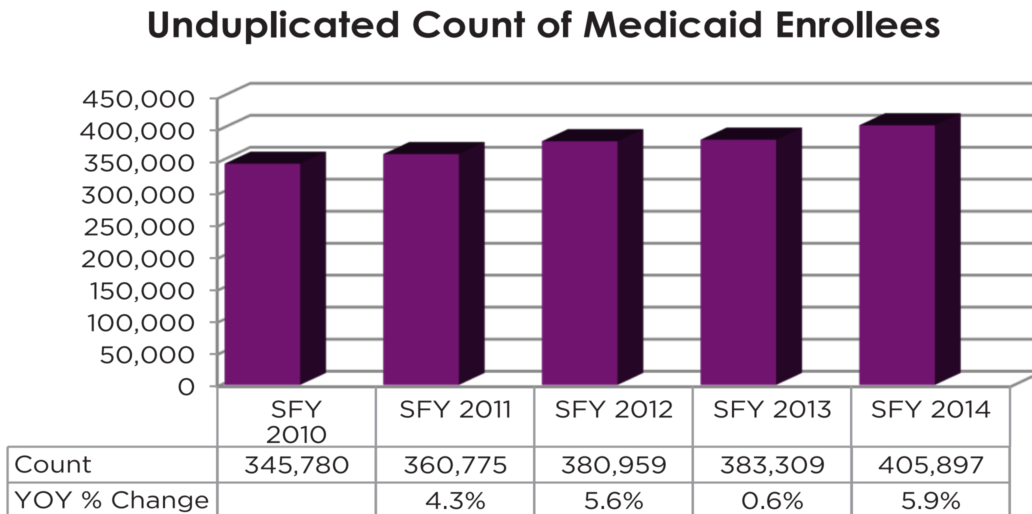
Table 13 provides a county level look at the average monthly Medicaid enrollment as a percent of population.

Table 13 : Average Monthly Enrollment as a Percent of County Population					
	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
BEAVER	11.5%	12.0%	11.8%	12.1%	11.8%
BOX ELDER	8.6%	8.9%	9.4%	9.8%	10.2%
CACHE	9.0%	9.1%	9.3%	9.3%	9.7%
CARBON	14.3%	14.5%	14.7%	15.3%	15.9%
DAGGETT	4.9%	4.4%	4.0%	4.5%	4.7%
DAVIS	6.4%	6.8%	7.1%	7.1%	7.3%
DUCHESNE	11.4%	11.5%	11.9%	11.0%	10.4%
EMERY	10.9%	10.6%	11.0%	11.1%	11.6%
GARFIELD	9.3%	8.6%	8.2%	9.1%	9.0%
GRAND	12.6%	12.0%	12.1%	11.6%	12.5%
IRON	13.1%	14.1%	14.6%	14.3%	15.0%
JUAB	11.1%	11.3%	11.2%	11.1%	11.1%
KANE	8.5%	8.5%	9.0%	8.9%	8.5%
MILLARD	12.3%	12.4%	11.7%	11.7%	11.7%
MORGAN	3.1%	3.4%	3.7%	3.6%	3.8%
PIUTE	15.9%	15.1%	14.4%	13.0%	14.0%
RICH	7.2%	9.0%	8.2%	7.5%	7.5%
SALT LAKE	9.1%	9.7%	10.2%	10.2%	10.4%
SAN JUAN	20.5%	21.8%	23.5%	23.8%	24.4%
SANPETE	11.2%	11.7%	12.0%	11.8%	12.1%
SEVIER	12.8%	13.0%	13.4%	13.5%	14.1%
SUMMIT	3.5%	3.7%	3.8%	3.6%	3.7%
TOOELE	8.6%	9.1%	9.7%	10.0%	10.5%
UINTAH	8.4%	8.5%	8.7%	8.5%	8.8%
UTAH	8.2%	8.5%	8.7%	8.6%	8.7%
WASATCH	5.4%	6.0%	6.2%	6.3%	6.3%
WASHINGTON	10.7%	11.5%	12.2%	12.0%	12.3%
WAYNE	8.2%	8.8%	8.4%	7.9%	8.1%
WEBER	10.1%	10.7%	11.4%	11.5%	11.7%
STATE OF UTAH	**8.9%**	**9.4%**	**9.8%**	**9.8%**	**10.0%**

UNDUPLICATED MEDICAID ENROLLMENT

An unduplicated enrollee is one who is counted only once within a specific fiscal year, regardless of the number of months that individual was eligible for Medicaid services. Thus an individual who was eligible for 12 months of service will be counted the same as an individual who was eligible for only one month of service.

Figure 12 is an illustration of the unduplicated number of enrollees eligible for Medicaid services.



	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Count	345,780	360,775	380,959	383,309	405,897
YOY % Change		4.3%	5.6%	0.6%	5.9%

FIGURE 12

Medicaid Enrollment

Table 14 breaks down the unduplicated enrollment count by race, age group, and gender.

Table 14: Enrollment by Race, Age Group and Gender SFY 2010 - SFY 2014							
Race	Age	Gender	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Asian	Age < 19	F	1,916	1,740	1,690	1,658	1,880
		M	1,962	1,913	1,834	1,784	1,983
	Age < 19 Total		3,895	3,653	3,524	3,442	3,863
	Age 19 - 64	F	2,925	1,801	1,888	2,000	1,931
		M	1,032	999	1,163	1,180	1,070
	Age 19 - 64 Total		3,957	2,800	3,051	3,180	3,001
	Age 65 or Older	F	740	747	761	778	759
		M	420	438	441	454	438
	Age 65 or Older Total		1,160	1,185	1,202	1,232	1,197
Asian Total			8,995	7,638	7,777	7,854	8,061
Black	Age < 19	F	3,258	3,170	3,079	3,019	3,055
		M	3,448	3,394	3,323	3,263	3,374
	Age < 19 Total		6,746	6,564	6,402	6,282	6,429
	Age 19 - 64	F	2,030	2,042	2,105	2,251	2,208
		M	1,229	1,207	1,310	1,412	1,377
	Age 19 - 64 Total		3,259	3,249	3,415	3,663	3,585
	Age 65 or Older	F	136	134	138	141	135
		M	80	84	93	105	101
	Age 65 or Older Total		216	218	231	246	236
Black Total			10,181	10,031	10,048	10,191	10,250
Native American	Age < 19	F	3,406	3,378	3,425	3,272	3,366
		M	3,560	3,530	3,524	3,387	3,492
	Age < 19 Total		7,005	6,909	6,949	6,659	6,858
	Age 19 - 64	F	701	790	958	974	996
		M	349	364	465	459	453
	Age 19 - 64 Total		1,050	1,154	1,423	1,433	1,449
	Age 65 or Older	F	396	405	418	414	392
		M	196	189	216	208	204
	Age 65 or Older Total		592	594	634	622	596
Native American Total			8,608	8,656	9,006	8,714	8,903
Pacific Islander	Age < 19	F	1,717	1,744	1,730	1,740	1,730
		M	1,864	1,891	1,866	1,876	1,892
	Age < 19 Total		3,591	3,635	3,596	3,616	3,622
	Age 19 - 64	F	914	886	852	943	896
		M	406	400	455	461	415
	Age 19 - 64 Total		1,320	1,286	1,307	1,404	1,311
	Age 65 or Older	F	93	91	92	91	84
		M	77	72	68	73	63
	Age 65 or Older Total		170	163	160	164	147
Pacific Islander Total			5,071	5,084	5,063	5,184	5080
White	Age < 19	F	88,326	84,941	79,623	74,204	81,018
		M	92,892	89,529	84,152	78,439	84,333
	Age < 19 Total		182,146	174,470	163,775	152,646	165,351
	Age 19 - 64	F	77,865	74,817	76,024	76,699	74,623
		M	36,004	35,636	37,370	36,909	35,476
	Age 19 - 64 Total		113,869	110,453	113,394	113,609	110,099
	Age 65 or Older	F	8,886	8,724	8,800	8,808	8,243
		M	3,822	3,768	3,873	3,912	3,672
	Age 65 or Older Total		12,708	12,492	12,673	12,720	11,915
White Total			307,795	297,415	289,842	278,971	287,365
Other	Age < 19	F	1,530	10,792	20,857	26,881	33,328
		M	1,499	11,245	21,972	28,261	35,377
	Age < 19 Total		3,029	22,037	42,829	55,144	68,705
	Age 19 - 64	F	1,550	6,597	10,134	10,105	9,724
		M	368	2,236	4,244	4,698	5,084
	Age 19 - 64 Total		1,918	8,833	14,378	14,803	14,808
	Age 65 or Older	F	130	723	1,330	1,659	1,850
		M	53	358	686	791	875
	Age 65 or Older Total		183	1,081	2,016	2,450	2,725
Other Total			5,130	31,951	59,223	72,395	86,238
Grand Total			345,780	360,775	380,959	383,309	405,897

Figure 13 shows each of the categories of assistance as a percent of total, statewide unduplicated Medicaid enrollment for SFY 2014.

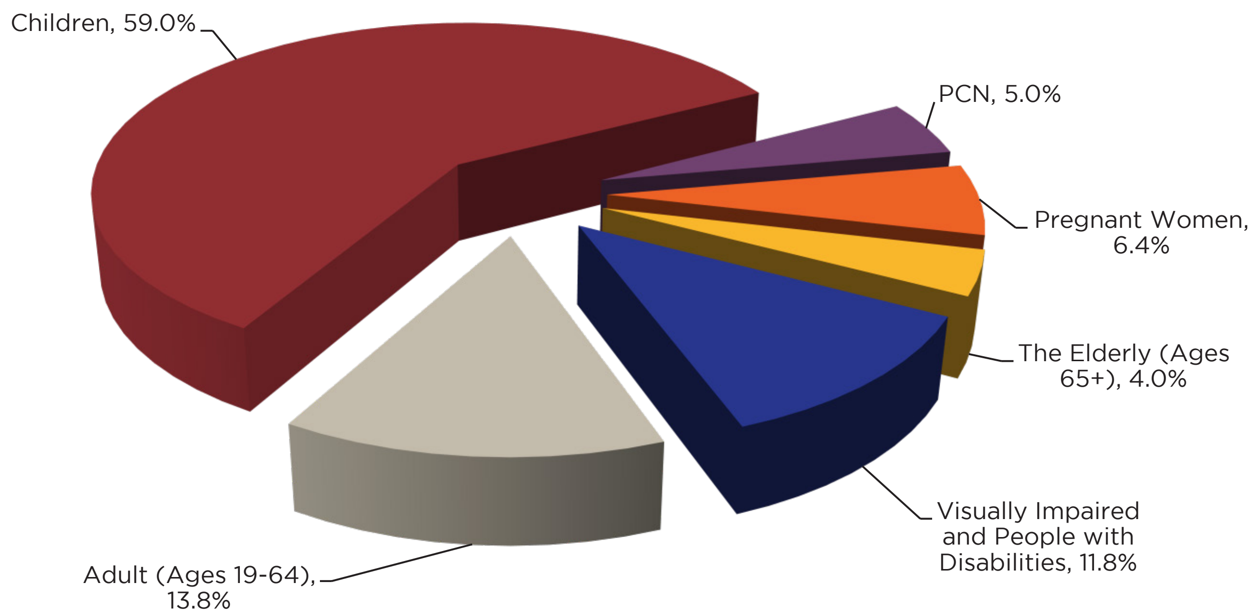


FIGURE 13

Table 15 presents the same information as Figure 13 from SFY 2010 to SFY 2014.

Table 15: Statewide Medicaid Enrollment Composition					
Category of Assistance	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Adult (Ages 19-64)	11.8%	12.7%	14.1%	14.4%	13.8%
Children	56.3%	57.3%	57.0%	56.7%	59.0%
PCN	7.5%	6.5%	6.1%	5.9%	5.0%
Pregnant Women	8.6%	7.6%	7.0%	6.9%	6.4%
The Elderly (Ages 65+)	4.0%	4.0%	4.1%	4.2%	4.0%
Visually Impaired and People with Disabilities	11.8%	11.9%	11.7%	11.9%	11.8%
Statewide Total	100.0%	100.0%	100.0%	100.0%	100.0%

Table 16 breaks out each category of assistance as a percent of each county's Medicaid enrollment. Table 15 in conjunction with Table 16 allows for comparisons between each county's Medicaid enrollment composition with the State's Medicaid enrollment composition.

Table 16: Medicaid Enrollment Composition by County						
County	Category of Assistance	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014
BEAVER	Adult (Ages 19-64)	9.3%	10.0%	11.4%	11.6%	10.7%
	Children	50.9%	52.3%	53.5%	50.3%	53.7%
	PCN	13.0%	12.9%	12.2%	13.1%	11.1%
	Pregnant Women	9.5%	8.8%	6.9%	6.3%	6.1%
	The Elderly (Ages 65+)	6.4%	5.8%	5.5%	6.7%	6.4%
	Visually Impaired and People with Disabilities	10.9%	10.2%	10.5%	12.1%	12.0%
BOX ELDER	Adult (Ages 19-64)	12.0%	12.0%	13.3%	14.2%	13.1%
	Children	57.0%	57.6%	57.3%	56.4%	58.9%
	PCN	9.0%	8.3%	7.4%	6.8%	5.3%
	Pregnant Women	7.6%	6.8%	6.5%	6.5%	6.6%
	The Elderly (Ages 65+)	3.1%	3.2%	3.3%	3.4%	3.1%
	Visually Impaired and People with Disabilities	11.3%	12.1%	12.1%	12.8%	13.0%
CACHE	Adult (Ages 19-64)	11.7%	12.3%	13.8%	14.4%	13.7%
	Children	58.0%	59.1%	58.9%	58.2%	61.1%
	PCN	7.6%	6.1%	5.4%	5.4%	4.5%
	Pregnant Women	10.7%	10.2%	9.8%	9.7%	8.9%
	The Elderly (Ages 65+)	2.7%	2.8%	2.7%	2.6%	2.4%
	Visually Impaired and People with Disabilities	9.3%	9.5%	9.5%	9.6%	9.4%
CARBON	Adult (Ages 19-64)	14.4%	14.9%	15.3%	15.9%	15.7%
	Children	47.1%	47.6%	48.6%	48.4%	49.8%
	PCN	9.3%	8.1%	7.3%	7.3%	7.1%
	Pregnant Women	6.6%	6.5%	6.3%	5.8%	4.9%
	The Elderly (Ages 65+)	4.7%	4.7%	4.5%	4.7%	4.6%
	Visually Impaired and People with Disabilities	17.8%	18.2%	18.1%	18.0%	17.8%
DAGGETT	Adult (Ages 19-64)	11.0%	17.6%	20.3%	13.0%	11.8%
	Children	52.1%	58.8%	54.4%	56.5%	56.5%
	PCN	9.6%	4.7%	11.4%	13.0%	8.2%
	Pregnant Women	9.6%	7.1%	2.5%	4.3%	4.7%
	The Elderly (Ages 65+)	4.1%	3.5%	2.5%	4.3%	4.7%
	Visually Impaired and People with Disabilities	13.7%	8.2%	8.9%	8.7%	14.1%
DAVIS	Adult (Ages 19-64)	13.2%	13.6%	15.1%	15.4%	14.9%
	Children	57.0%	58.0%	57.7%	57.1%	59.2%
	PCN	7.4%	6.5%	5.9%	5.9%	4.8%
	Pregnant Women	7.7%	7.2%	6.6%	6.5%	6.2%
	The Elderly (Ages 65+)	2.9%	3.0%	3.1%	3.4%	3.2%
	Visually Impaired and People with Disabilities	11.7%	11.7%	11.6%	11.8%	11.8%
DUCHESNE	Adult (Ages 19-64)	12.1%	12.8%	15.0%	13.8%	12.8%
	Children	53.8%	54.3%	53.9%	54.4%	57.0%
	PCN	6.9%	5.2%	4.9%	5.0%	4.3%
	Pregnant Women	7.1%	7.4%	6.8%	6.5%	5.9%
	The Elderly (Ages 65+)	5.0%	5.4%	4.7%	4.9%	4.9%
	Visually Impaired and People with Disabilities	15.1%	14.8%	14.7%	15.4%	15.1%
EMERY	Adult (Ages 19-64)	10.4%	11.7%	12.2%	13.0%	14.2%
	Children	53.4%	54.0%	55.7%	56.7%	58.2%
	PCN	11.6%	9.8%	7.8%	7.1%	5.9%
	Pregnant Women	6.2%	6.1%	6.1%	5.4%	4.1%
	The Elderly (Ages 65+)	5.0%	4.8%	4.7%	4.9%	4.2%
	Visually Impaired and People with Disabilities	13.6%	13.7%	13.5%	12.9%	13.2%
GARFIELD	Adult (Ages 19-64)	7.3%	9.4%	10.9%	10.4%	9.6%
	Children	47.2%	46.5%	47.1%	48.7%	54.5%
	PCN	19.1%	17.1%	17.1%	14.9%	11.0%
	Pregnant Women	7.8%	6.4%	6.5%	7.8%	6.7%
	The Elderly (Ages 65+)	7.1%	8.3%	6.8%	6.1%	6.6%
	Visually Impaired and People with Disabilities	11.5%	12.3%	11.7%	12.1%	11.6%

Table 16: Medicaid Enrollment Composition by County						
County	Category of Assistance	SFY2010	SFY2011	SFY2021	SFY2013	SFY2014
GRAND	Adult (Ages 19-64)	10.9%	11.5%	12.7%	12.8%	12.8%
	Children	47.8%	48.7%	50.3%	49.2%	50.7%
	PCN	15.9%	13.6%	10.4%	9.3%	8.4%
	Pregnant Women	7.7%	7.0%	6.5%	7.7%	7.1%
	The Elderly (Ages 65+)	4.8%	4.9%	5.8%	6.6%	6.3%
	Visually Impaired and People with Disabilities	12.9%	14.4%	14.3%	14.4%	14.8%
IRON	Adult (Ages 19-64)	11.5%	12.9%	14.4%	14.8%	14.0%
	Children	54.0%	54.6%	54.4%	53.7%	56.7%
	PCN	12.6%	10.9%	10.0%	9.7%	8.2%
	Pregnant Women	9.0%	8.1%	7.7%	7.2%	6.8%
	The Elderly (Ages 65+)	2.8%	2.9%	2.9%	3.1%	3.0%
	Visually Impaired and People with Disabilities	10.0%	10.6%	10.6%	11.5%	11.3%
JUAB	Adult (Ages 19-64)	11.2%	11.9%	12.0%	13.3%	12.6%
	Children	57.1%	58.0%	59.1%	58.2%	59.3%
	PCN	7.7%	6.1%	5.6%	4.7%	4.4%
	Pregnant Women	7.6%	6.4%	5.6%	5.4%	5.7%
	The Elderly (Ages 65+)	4.0%	4.0%	4.2%	4.4%	4.2%
	Visually Impaired and People with Disabilities	12.5%	13.5%	13.5%	14.0%	13.8%
KANE	Adult (Ages 19-64)	9.2%	10.6%	13.8%	11.8%	12.2%
	Children	49.5%	50.0%	47.7%	48.3%	52.6%
	PCN	12.9%	11.6%	11.2%	11.6%	8.5%
	Pregnant Women	8.0%	7.9%	7.7%	7.4%	6.1%
	The Elderly (Ages 65+)	7.0%	7.0%	7.5%	7.5%	7.6%
	Visually Impaired and People with Disabilities	13.3%	13.0%	12.1%	13.5%	13.1%
MILLARD	Adult (Ages 19-64)	8.8%	9.7%	12.4%	12.6%	10.5%
	Children	54.7%	55.8%	57.2%	56.4%	60.0%
	PCN	13.5%	12.0%	10.7%	10.1%	9.0%
	Pregnant Women	7.5%	6.2%	5.1%	5.4%	4.9%
	The Elderly (Ages 65+)	5.2%	5.6%	4.9%	5.2%	5.2%
	Visually Impaired and People with Disabilities	10.3%	10.8%	9.8%	10.4%	10.4%
MORGAN	Adult (Ages 19-64)	9.1%	9.8%	12.0%	13.8%	12.3%
	Children	60.3%	56.7%	56.2%	54.4%	61.5%
	PCN	8.9%	11.5%	10.5%	9.6%	5.8%
	Pregnant Women	9.3%	8.7%	8.9%	8.6%	6.7%
	The Elderly (Ages 65+)	2.6%	2.5%	2.0%	3.0%	2.3%
	Visually Impaired and People with Disabilities	9.7%	10.8%	10.4%	10.6%	11.4%
PIUTE	Adult (Ages 19-64)	8.2%	11.0%	9.7%	10.2%	14.2%
	Children	50.5%	52.8%	53.0%	48.5%	52.7%
	PCN	22.8%	18.5%	18.2%	19.5%	14.0%
	Pregnant Women	5.3%	3.5%	2.2%	4.3%	5.7%
	The Elderly (Ages 65+)	4.2%	3.5%	4.1%	4.0%	2.6%
	Visually Impaired and People with Disabilities	9.0%	10.7%	12.9%	13.5%	10.8%
RICH	Adult (Ages 19-64)	8.5%	13.2%	13.8%	14.7%	13.6%
	Children	59.2%	57.2%	59.1%	60.3%	60.3%
	PCN	9.6%	9.5%	6.7%	6.6%	5.8%
	Pregnant Women	9.2%	8.9%	6.7%	5.1%	6.1%
	The Elderly (Ages 65+)	2.5%	2.5%	2.3%	1.5%	2.0%
	Visually Impaired and People with Disabilities	11.0%	8.6%	11.4%	11.8%	12.2%
SALT LAKE	Adult (Ages 19-64)	11.8%	12.8%	14.1%	14.3%	13.6%
	Children	55.3%	56.5%	56.2%	56.0%	57.9%
	PCN	6.3%	5.6%	5.5%	5.3%	4.7%
	Pregnant Women	8.6%	7.2%	6.5%	6.4%	6.0%
	The Elderly (Ages 65+)	4.8%	4.9%	5.0%	5.2%	5.0%
	Visually Impaired and People with Disabilities	13.2%	13.0%	12.8%	12.9%	12.8%

Table 16: Medicaid Enrollment Composition by County						
County	Category of Assistance	FY2010	FY2011	FY2012	FY2013	FY2014
SAN JUAN	Adult (Ages 19-64)	13.7%	13.9%	17.1%	16.6%	15.7%
	Children	53.5%	54.1%	51.7%	51.9%	53.7%
	PCN	4.5%	4.9%	5.9%	6.8%	6.6%
	Pregnant Women	6.1%	5.4%	5.2%	5.5%	5.1%
	The Elderly (Ages 65+)	10.9%	10.6%	9.8%	9.3%	8.9%
	Visually Impaired and People with Disabilities	11.3%	11.0%	10.3%	9.8%	9.9%
SANPETE	Adult (Ages 19-64)	9.7%	10.6%	11.5%	11.9%	11.8%
	Children	56.3%	57.5%	57.7%	57.8%	61.0%
	PCN	12.2%	10.5%	9.4%	9.1%	6.9%
	Pregnant Women	7.2%	6.5%	6.2%	6.1%	5.3%
	The Elderly (Ages 65+)	3.6%	4.0%	3.9%	3.9%	4.0%
	Visually Impaired and People with Disabilities	11.0%	11.0%	11.3%	11.2%	11.0%
SEVIER	Adult (Ages 19-64)	11.8%	12.6%	14.5%	15.5%	15.3%
	Children	52.8%	53.3%	53.0%	51.4%	53.8%
	PCN	11.5%	10.3%	10.2%	9.8%	8.3%
	Pregnant Women	7.9%	6.9%	5.6%	5.6%	5.7%
	The Elderly (Ages 65+)	4.3%	4.4%	4.7%	5.0%	4.3%
	Visually Impaired and People with Disabilities	11.6%	12.5%	12.0%	12.8%	12.6%
SUMMIT	Adult (Ages 19-64)	7.6%	9.4%	11.2%	10.4%	9.0%
	Children	65.3%	66.7%	65.7%	65.0%	67.9%
	PCN	6.5%	5.2%	5.1%	5.5%	4.5%
	Pregnant Women	10.6%	8.1%	7.0%	6.8%	6.2%
	The Elderly (Ages 65+)	2.3%	2.4%	2.7%	3.1%	3.5%
	Visually Impaired and People with Disabilities	7.7%	8.1%	8.2%	9.3%	8.9%
TOOELE	Adult (Ages 19-64)	13.7%	14.2%	15.2%	15.9%	16.1%
	Children	55.6%	57.0%	57.2%	56.5%	58.4%
	PCN	7.1%	6.3%	5.8%	5.6%	4.9%
	Pregnant Women	7.7%	6.8%	6.5%	6.3%	5.9%
	The Elderly (Ages 65+)	3.4%	3.3%	3.2%	3.1%	2.8%
	Visually Impaired and People with Disabilities	12.5%	12.3%	12.1%	12.6%	11.9%
UINTAH	Adult (Ages 19-64)	13.8%	14.2%	15.7%	15.2%	15.2%
	Children	56.7%	57.1%	57.7%	58.7%	59.5%
	PCN	5.3%	4.4%	3.9%	3.6%	3.3%
	Pregnant Women	8.7%	8.5%	7.5%	7.8%	7.3%
	The Elderly (Ages 65+)	3.9%	4.4%	4.2%	3.9%	3.8%
	Visually Impaired and People with Disabilities	11.5%	11.4%	11.1%	10.7%	10.8%
UTAH	Adult (Ages 19-64)	11.5%	12.6%	13.9%	14.3%	13.6%
	Children	59.0%	60.1%	59.6%	59.3%	62.3%
	PCN	7.7%	6.2%	5.9%	5.5%	4.3%
	Pregnant Women	9.9%	9.1%	8.4%	8.4%	7.8%
	The Elderly (Ages 65+)	2.4%	2.5%	2.7%	2.8%	2.7%
	Visually Impaired and People with Disabilities	9.5%	9.5%	9.6%	9.7%	9.4%
WASATCH	Adult (Ages 19-64)	8.6%	10.6%	12.7%	12.8%	11.2%
	Children	60.6%	61.2%	61.4%	62.6%	65.7%
	PCN	8.9%	7.6%	6.6%	5.6%	4.8%
	Pregnant Women	9.3%	8.0%	7.2%	6.8%	7.0%
	The Elderly (Ages 65+)	3.2%	3.2%	2.9%	2.8%	3.0%
	Visually Impaired and People with Disabilities	9.4%	9.4%	9.3%	9.4%	8.5%
WASHINGTON	Adult (Ages 19-64)	9.9%	11.8%	13.6%	14.1%	13.3%
	Children	59.8%	60.5%	59.9%	59.8%	62.7%
	PCN	9.1%	7.8%	7.1%	6.8%	5.8%
	Pregnant Women	8.9%	7.7%	7.1%	6.7%	6.1%
	The Elderly (Ages 65+)	3.9%	3.8%	3.9%	3.9%	3.8%
	Visually Impaired and People with Disabilities	8.4%	8.4%	8.5%	8.6%	8.4%

Table 16: Medicaid Enrollment Composition by County

County	Category of Assistance	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014
WAYNE	Adult (Ages 19-64)	10.2%	11.9%	13.1%	12.1%	12.2%
	Children	57.5%	58.3%	58.5%	53.9%	55.2%
	PCN	10.5%	9.2%	10.3%	10.9%	9.0%
	Pregnant Women	9.2%	7.9%	4.6%	5.8%	6.5%
	The Elderly (Ages 65+)	3.9%	4.2%	4.1%	5.2%	6.3%
	Visually Impaired and People with Disabilities	8.7%	8.4%	9.3%	12.1%	10.9%
WEBER	Adult (Ages 19-64)	12.1%	12.9%	14.8%	14.9%	14.0%
	Children	54.9%	55.4%	55.1%	54.9%	56.1%
	PCN	6.6%	6.1%	5.5%	5.4%	5.2%
	Pregnant Women	7.6%	6.8%	6.1%	6.2%	6.0%
	The Elderly (Ages 65+)	4.1%	4.2%	4.2%	4.2%	4.0%
	Visually Impaired and People with Disabilities	14.6%	14.5%	14.3%	14.4%	14.6%

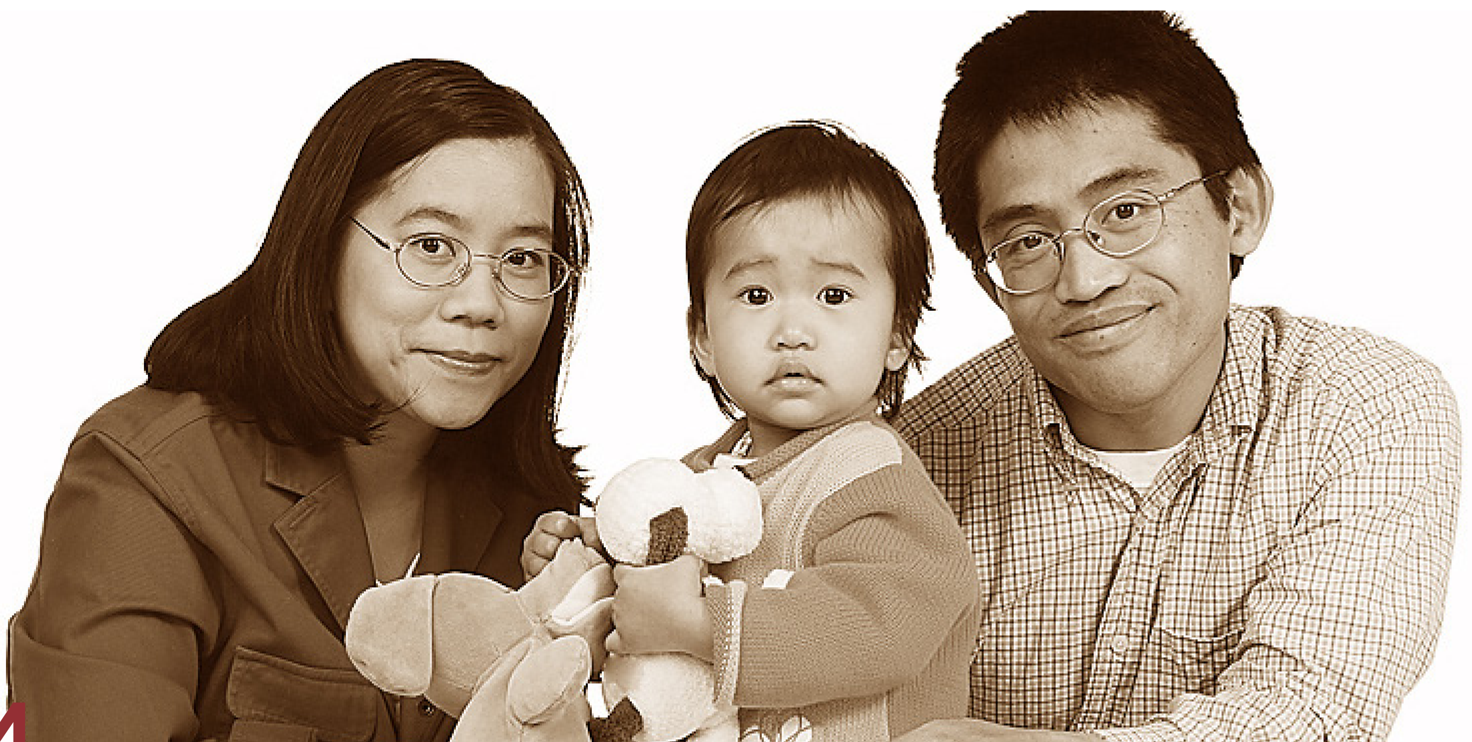
Medicaid Delivery and Payment Services

Medicaid expenditures are related to the enrollment levels which, in turn, are affected by economic, demographic, and age-mix factors. Services are provided to Medicaid enrollees either directly by licensed providers, though fee-for service (FFS) payments, or through contracts with managed care organizations (MCO).

Under federal law, participating providers must accept the reimbursement level as payment in full. Several methods are used to determine provider reimbursement, including limited fees-for-service, negotiated capitation rates, and client acuity-based rates for nursing home services.

Services covered by Medicaid can be classified into the following major service groups:

- **Hospital Care** –Services delivered through inpatient and outpatient hospital facilities.
- **Physicians** – All physician-delivered services.
- **Pharmacy** – Prescription drug services.
- **Other Services** – Includes a wide range of medical services, such as vision care, home health care, rural health clinics and prenatal care.
- **Long–Term Care** – Services provided to individuals who are either elderly or have a disability. Services can be provided in either a facility-based or community-based setting.



Providers

Medical services are provided to Medicaid clients by any willing provider who bills the Division of Medicaid and Health Financing (DMHF) directly. Table 17 provides a unique count of FFS providers by category of service.

Table 17: Number of Participating Fee-for-service Providers by Category of Service

Category of Service	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Aging Waiver Service	180	192	230	321	360
Ambulatory Surgical Services	46	48	43	42	43
Buy Out	1,602	1,312	1,316	1,312	1,343
Chiropractic Services	209	205	192	183	169
Contracted Mental Hlth Srvcs	185	320	239	192	210
Custody Medical	124	134	140	134	279
Dental Services	715	728	782	820	804
Early Intervention	17	17	16	16	42
ESRD Kidney Dialysis Srvcs	42	43	42	41	16
Federally Qualified Health Cntrs	25	27	27	27	31
HIT Dual Elig Hosp Yr1 Meaningful Use	0	0	0	16	19
HIT Elig Prov Yr1 Adopt	0	0	105	218	331
HIT Elig Prov Yr2 Meaningful Use	0	0	0	17	92
Home Health Services	160	161	183	189	200
Home/Comm Waiver Contract Srvcs	240	238	253	371	191
Houghton Lawsuit Pay Out	0	0	1,367	0	0
ICF/MR1 (LOC 4)	16	15	15	15	16
Independent Lab and/or X-Ray Srvcs	89	95	110	107	115
Inpatient Hospital Srvcs, General	188	164	192	205	202
Intensive Skilled Care	11	0	0	16	0
Medical Supply Services	541	485	481	472	456
Medical Transportation	122	113	129	116	118
Mental Health Services	11	0	15	78	139
New Choices Waiver Srvcs	190	192	212	256	276
Nursing Facility I (NF I)	115	118	112	109	114
Nursing Facility II (NF II)	98	95	91	84	87
Nursing Facility III (NF III)	101	101	95	96	104
Occupational Therapy	52	40	36	36	42
Osteopathic Services	337	322	373	386	393
Other	87	73	70	58	90
Outpatient Hospital Srvcs, General	367	379	397	382	361
Pediatric/Family Nurse Pract	177	188	215	229	261
Personal Care	47	59	60	59	56
Pharmacy	592	580	580	583	603
Physical Therapy Services	242	229	252	247	245
Physician Services	3,443	3,526	3,835	3,626	3,465
Podiatry Services	118	111	123	117	114
Psychologist Services	84	93	104	112	110
QMB-Only Services	162	160	215	204	206
Rural Health Clinic Services	17	17	23	23	20
Skills Developement	32	32	33	34	35
Specialized Nursing Srvcs	123	115	129	125	123
Speech and Hearing Services	96	75	88	95	96
Substance Abuse Treatment Srvcs	35	34	48	55	65
Targeted Case Mngmnt Srvcs	0	38	28	26	27
Vision Care Services	264	256	263	259	273
Well Child Care (EPSDT) Srvcs	643	646	603	546	486
Total	**11,945**	**11,776**	**13,862**	**12,655**	**12,828**

Table 18 shows the reimbursement amounts to FFS providers by category of service.

Table 18: Reimbursement Amounts to Fee-for-Service Providers by Category of Service					
Category of Service	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Aging Waiver Service	$3,524,300	$3,544,200	$4,215,300	$4,249,500	$4,036,627
Ambulatory Surgical Services	$9,656,600	$7,893,300	$6,769,800	$5,885,100	$5,303,232
Buy Out	$517,900	$418,300	$398,700	$393,500	$416,555
Chiropractic Services	$155,200	$145,700	$131,100	$114,600	$120,870
Contracted Mental Hlth Srvcs	$47,809,800	$16,496,300	$16,796,600	$16,840,200	$17,533,966
Custody Medical	$131,700	$153,400	$54,300	$48,600	$156,676
Dental Services	$31,857,500	$35,651,300	$38,795,500	$42,161,800	$23,546,744
Early Intervention	$6,544,100	$9,089,600	$8,173,900	$8,594,600	$1,643,086
ESRD Kidney Dialysis Srvcs	$2,286,600	$1,323,800	$1,900,100	$1,621,100	$8,662,765
Federally Qualified Health Cntrs	$5,354,400	$6,022,800	$5,706,300	$5,404,700	$4,548,629
HIT Dual Elig Hosp Yr1 Meaningful Use	$0	$0	$0	$9,870,800	$13,534,332
HIT Elig Prov Yr1 Adopt	$0	$0	$3,987,900	$5,301,200	$6,268,757
HIT Elig Prov Yr2 Meaningful Use	$0	$0	$0	$289,000	$1,164,508
Home Health Services	$27,856,800	$27,511,200	$27,502,500	$30,611,500	$21,480,791
Home/Comm Waiver Contract Srvcs	$154,201,800	$154,214,200	$160,007,200	$171,057,500	$172,644,581
Houghton Lawsuit Pay Out	$0	$0	$2,332,200	$0	$0
ICF/MR1 (LOC 4)	$30,730,100	$31,509,700	$32,305,100	$31,741,700	$32,166,519
Independent Lab and/or X-Ray Srvcs	$3,064,100	$3,228,400	$3,118,900	$2,971,900	$3,815,499
Inpatient Hospital Srvcs, General	$332,696,000	$509,246,700	$511,698,100	$410,531,100	$254,966,654
Intensive Skilled Care	$0	$0	$0	$17,829,500	$0
Medical Supply Services	$12,934,500	$14,389,400	$15,895,400	$13,973,800	$10,654,322
Medical Transportation	$6,188,500	$6,429,600	$6,621,500	$7,010,700	$8,280,208
Mental Health Services	$0	$0	$121,756,700	$119,774,200	$131,146,801
New Choices Waiver Srvcs	$18,972,700	$21,991,500	$24,780,800	$29,608,000	$35,795,841
Nursing Facility I (NF I)	$8,507,600	$7,046,000	$6,222,600	$4,707,500	$4,080,642
Nursing Facility II (NF II)	$61,654,700	$54,022,400	$46,548,300	$27,487,300	$16,247,347
Nursing Facility III (NF III)	$71,317,300	$86,360,000	$102,670,200	$120,422,400	$138,192,448
Occupational Therapy	$86,300	$111,900	$109,900	$77,700	$48,080
Osteopathic Services	$7,128,900	$7,982,500	$7,975,600	$7,506,700	$6,205,343
Other	$159,172,900	$181,927,400	$56,003,400	$35,900,900	$76,775,678
Outpatient Hospital Srvcs, General	$119,076,500	$107,156,800	$103,533,700	$70,227,400	$63,966,311
Pediatric/Family Nurse Pract	$532,900	$523,000	$506,200	$482,600	$420,736
Personal Care	$1,883,500	$2,068,300	$2,768,400	$3,456,800	$2,917,170
Pharmacy	$158,605,600	$172,956,500	$183,388,900	$137,387,000	$116,253,385
Physical Therapy Services	$411,900	$476,300	$472,900	$354,600	$307,392
Physician Services	$114,613,100	$112,655,800	$101,608,500	$86,853,100	$70,476,033
Podiatry Services	$432,900	$457,700	$453,900	$480,500	$390,536
Psychologist Services	$269,000	$315,200	$305,600	$322,400	$321,397
QMB-Only Services	$352,500	$320,200	$389,700	$419,100	$438,888
Rural Health Clinic Services	$1,329,500	$1,250,500	$1,186,500	$1,225,400	$1,038,776
Skills Developement	$20,430,100	$25,359,800	$22,487,400	$26,905,000	$30,169,720
Specialized Nursing Srvcs	$3,153,200	$3,369,100	$3,077,600	$2,559,600	$1,930,014
Speech and Hearing Services	$299,300	$348,000	$373,300	$321,700	$184,644
Substance Abuse Treatment Srvcs	$9,775,900	$9,730,600	$10,687,100	$18,744,400	$18,012,454
Targeted Case Mngmnt Srvcs	$0	$55,400	$50,100	$60,000	$9,654
Vision Care Services	$2,036,400	$2,278,400	$2,219,700	$1,903,100	$1,538,298
Well Child Care (EPSDT) Srvcs	$10,929,200	$11,272,700	$10,849,900	$8,423,900	$6,721,681
Grand Total	**$1,446,481,800**	**$1,637,303,900**	**$1,656,837,300**	**$1,492,113,700**	**$1,314,534,586**

Managed Care

Managed care has been part of the Medicaid service delivery system since the 1990's. In a managed care delivery system, Medicaid recipients receive their health care through an organization under contract with DMHF to provide Medicaid covered services. DMHF uses waiver authority under Section 1915(b) of the Social Security Act to implement managed care delivery systems.

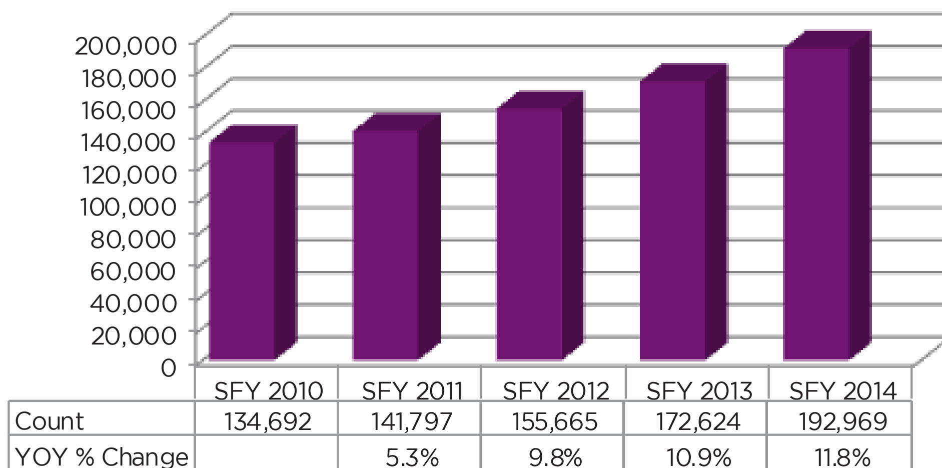
Utah's 1915(b) Choice of Health Care Delivery Program waiver grants authority to DMHF to require Medicaid recipients living in Weber, Davis, Salt Lake, and Utah counties to select a health plan. Health plans are responsible to provide Medicaid services through their provider network. Some health plans are available in other counties of the state. Enrollment in a health plan outside the Wasatch Front is voluntary.

The 1915(b) Prepaid Mental Health Plan waiver allows DMHF to enroll all Medicaid recipients in behavioral health plans statewide. Behavioral health services are provided under full risk capitated contracts administered under the statutory authority of the local county mental health and substance abuse authorities.

In September 2013, DMHF implemented the 1915(b) Dental Choices waiver which requires Medicaid recipients eligible for full dental services (pregnant women and children), in Weber, Davis, Salt Lake and Utah counties to enroll in a managed care dental plan.

Figure 14 illustrates the monthly average number of Medicaid recipients receiving services through managed care.

Average Managed Care Enrollees per Month

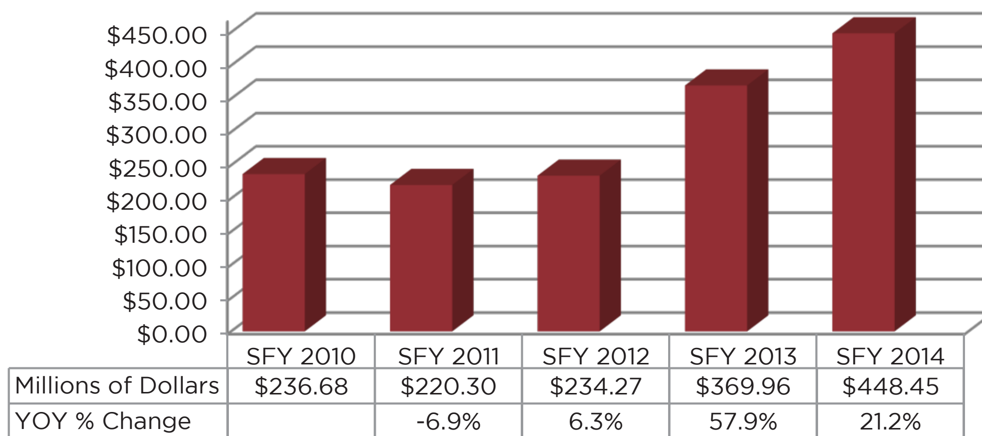


	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Count	134,692	141,797	155,665	172,624	192,969
YOY % Change		5.3%	9.8%	10.9%	11.8%

FIGURE 14

Figure 15 illustrates statewide managed care expenditures by fiscal year. The large year to year percent growth seen between SFYs 2012 and 2013, is attributed to the shift to accountable care organizations (ACOs). With this shift, some of the recipients and expenditures that were previously classified as fee-for-service are now categorized as managed care services. These include FFS hospital, FFS physician services, FFS pharmacy services, and other FFS long-term care services.

Managed Care Expenditures



	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Millions of Dollars	$236.68	$220.30	$234.27	$369.96	$448.45
YOY % Change		-6.9%	6.3%	57.9%	21.2%

FIGURE 15

MANAGED CARE: ACCOUNTABLE CARE ORGANIZATIONS

In response to concerns that the Utah Medicaid growth rates exceeded the State's annual revenue growth rate for the past two decades and concerns about the long-term sustainability of the Medicaid program, Senate Bill 180, Medicaid Reform, was passed during the 2011 General Session of the Utah State Legislature. In part, the bill requires that: "The Department shall develop a proposal to amend the State Plan for the Medicaid program in a way that maximizes replacement of the fee-for-service delivery model with one or more risk-based delivery models." In order to maximize replacement of the FFS delivery model, Senate Bill 180 provides some specific goals and guidance:

1. Restructure the program's provider payment provisions to reward health care providers for delivering the most appropriate service at the lowest cost that maintains or improves recipient health status. The Legislation included:
   (a) Identifying evidence-based practices and other mechanisms necessary to reward providers for delivering the most appropriate services at the lowest cost;
   (b) Paying providers for packages of services delivered over entire episodes of illness;
   (c) Rewarding providers for delivering services that make the most positive contribution to maintaining and improving a recipient's health status;
   (d) Using providers that deliver the most appropriate services at the lowest cost; and
2. Restructure the program to bring the rate of growth in Medicaid more in line with the overall growth in General Funds.
3. Restructure the program's cost sharing provisions and add incentives to reward recipients for personal efforts to maintain and improve their health status.

To achieve these goals, effective January 2013, DMHF implemented Accountable Care Organizations (ACOs). There are four ACOs currently operating on behalf of Medicaid: Health Choice Utah, Healthy U, Molina Healthcare of Utah, and SelectHealth Community Care.

The goals of the ACOs are to maintain quality of care and improve health outcomes for Medicaid recipients and to control costs by keeping the Medicaid cost growth rate from exceeding the State General Fund growth rate. All managed care contracts are full risk capitated contracts and therefore assume the risk for all health care costs for their enrollees. DMHF contracts with a nationally recognized actuarial firm to develop member per month rates paid to managed care organizations, which must be actuarially certified and approved by CMS.

Figure 16 is a breakdown of the monthly average number of Medicaid recipients by rate cell served by all ACOs during SFY 2014. The children from ages 1 to 18 years old, both male and female together, constitute over 60 percent of ACO recipients. Non-traditional females (ages 19 through 64) make up 8.7 percent, which is about 2.6 times more than non-traditional males. Males and females of all ages with disabilities account for 14.5 percent of all recipients, followed by the birth to one year old category at 7.6 percent. All of the other rate cells, aggregated, compose 4.9 percent of the recipient total.

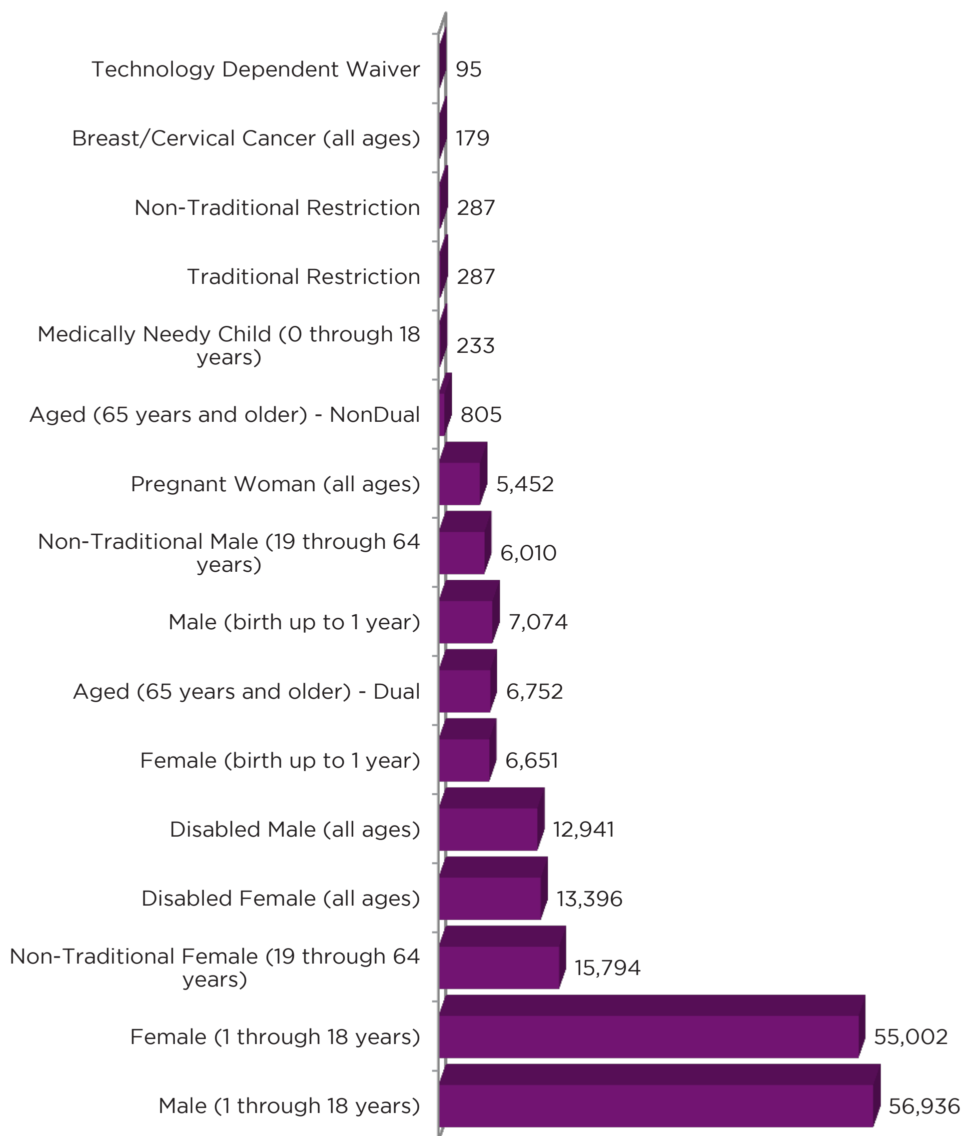


FIGURE 16

Figure 17 shows the weighted average base rates for each rate cell in SFY 2014. The Technology Dependent Waiver rate cell has the largest base rate but the least amount of member months. By contrast the males and females between the ages of 1 and 18 account for the lowest base rates but the highest number of member months.

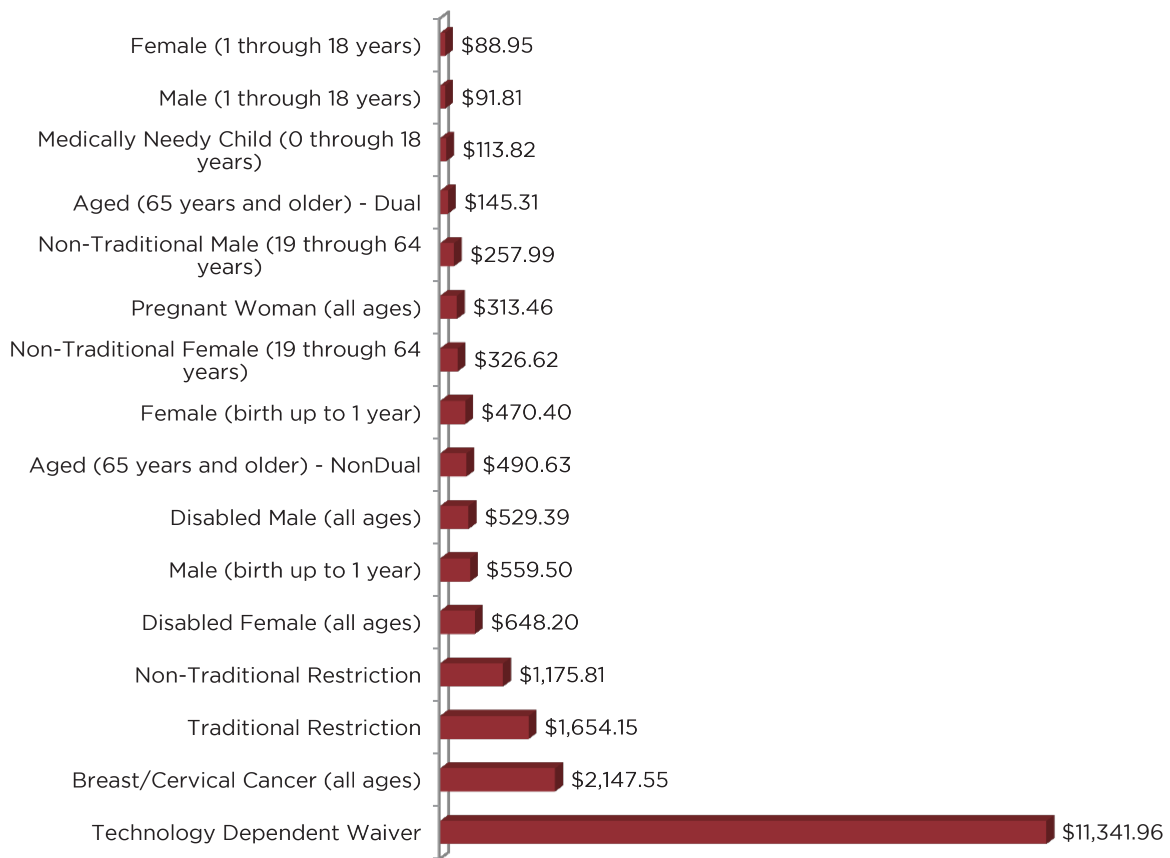


FIGURE 17

MANAGED CARE: BEHAVIORAL HEALTH

The Utah State Legislature appropriates state funds to the Utah Department of Human Services (DHS), specifically the Division of Substance Abuse and Mental Health (DSAMH), the State's mental health and substance abuse authority. The DSAMH allocates these state general funds to the local county mental health and substance abuse authorities. In accordance with Utah Code Annotated, 17-43-301 and 17-43-201, the local county mental health authorities and substance abuse authorities are statutorily responsible for the provision of public mental health and substance abuse services to citizens in their respective counties.

Local county authorities provide the Medicaid state matching share for Medicaid behavioral health services except for inpatient services. Therefore, as these are optional Medicaid services, the state has entered into contracts with the local county authorities or their contracted entities for the provision of Medicaid mental health and substance abuse services. The local county authorities provide the state match share to fund the outpatient portion of Pre-paid Mental Health Plan premiums. The state share of inpatient services is directly appropriated to the DSAMH.

Table 19 shows the average monthly behavioral health enrollment. The counties are grouped in accordance with their shared providers. For instance, since Bear River Mental Health provides behavioral health services to the residents of Cache, Box Elder and Rich Counties, these counties are grouped together in Table 19.

Table 19: Behavioral Health Average Monthly Enrollment by Local Health District

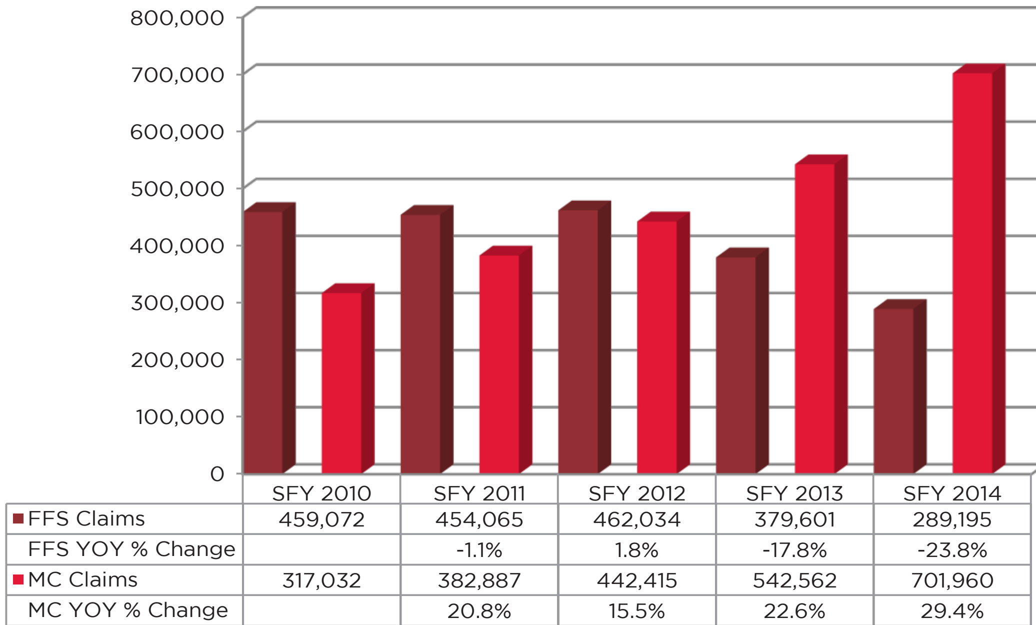
County	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
CARBON, EMERY & GRAND	4,607	4,749	4,911	5,041	1,223
DAVIS	17,320	18,967	20,405	20,875	5,044
CACHE, BOX ELDER & RICH	12,761	13,657	14,346	14,702	3,572
JUAB, MILLARD, PIUTE, SANPETE, SEVIER & WAYNE	7,502	7,959	8,142	8,177	1,972
SALT LAKE, SUMMIT & TOOELE	89,704	98,626	105,137	107,944	26,234
UTAH & WASATCH	37,133	40,611	42,806	43,219	10,379
MORGAN & WEBER	21,230	23,229	25,175	25,701	6,184
DAGGET, DUCHESNE, SAN JUAN & UINTAH	4,418	4,614	4,848	4,800	1,973
BEAVER, GARFIELD, IRON, KANE & WASHINGTON	19,312	21,547	23,327	23,724	5,721

Utilization and Expenditures

HOSPITAL CARE

Medicaid covers services performed in an inpatient setting at a hospital. There is an annual co-payment for inpatient services for non-emergent stays. Most outpatient services are covered on a referral basis and may be subject to prior approval.

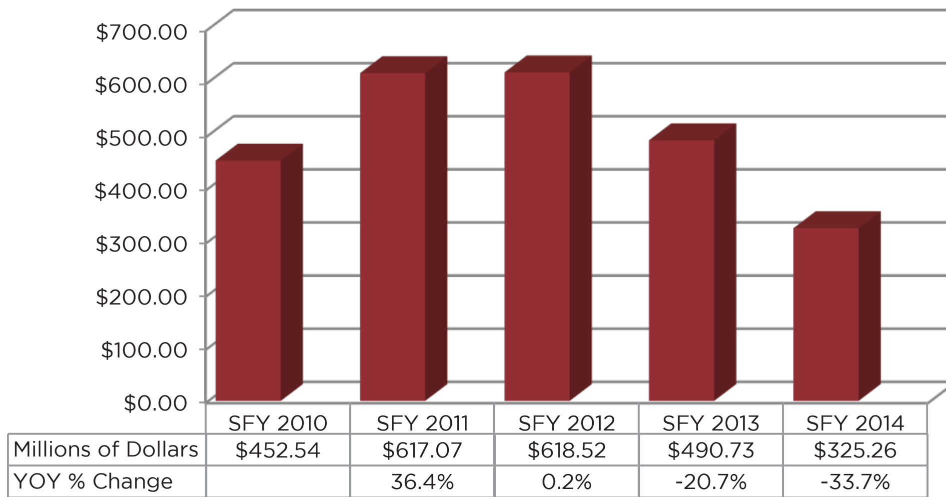
Figure 18 shows the number of hospital care services claims for both inpatient and outpatient hospital facilities. The decline in the number of FFS claims in FY 2013 and FY 2014 were offset by the increase in the number of managed care claims ("MC claims" in the charts) in both years. The shift in claims between FFS and managed care is attributable to the implementation of the ACO model during SFY 2013.



	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
FFS Claims	459,072	454,065	462,034	379,601	289,195
FFS YOY % Change		-1.1%	1.8%	-17.8%	-23.8%
MC Claims	317,032	382,887	442,415	542,562	701,960
MC YOY % Change		20.8%	15.5%	22.6%	29.4%

FIGURE 18

Figure 19 shows expenditures for FFS hospital care services. The dramatic drop in SFY 2013 and again in SFY 2014 is largely attributable to the establishment of ACOs. Given that managed care expenditures are capitated, they are not included in figure 19.



	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Millions of Dollars	$452.54	$617.07	$618.52	$490.73	$325.26
YOY % Change		36.4%	0.2%	-20.7%	-33.7%

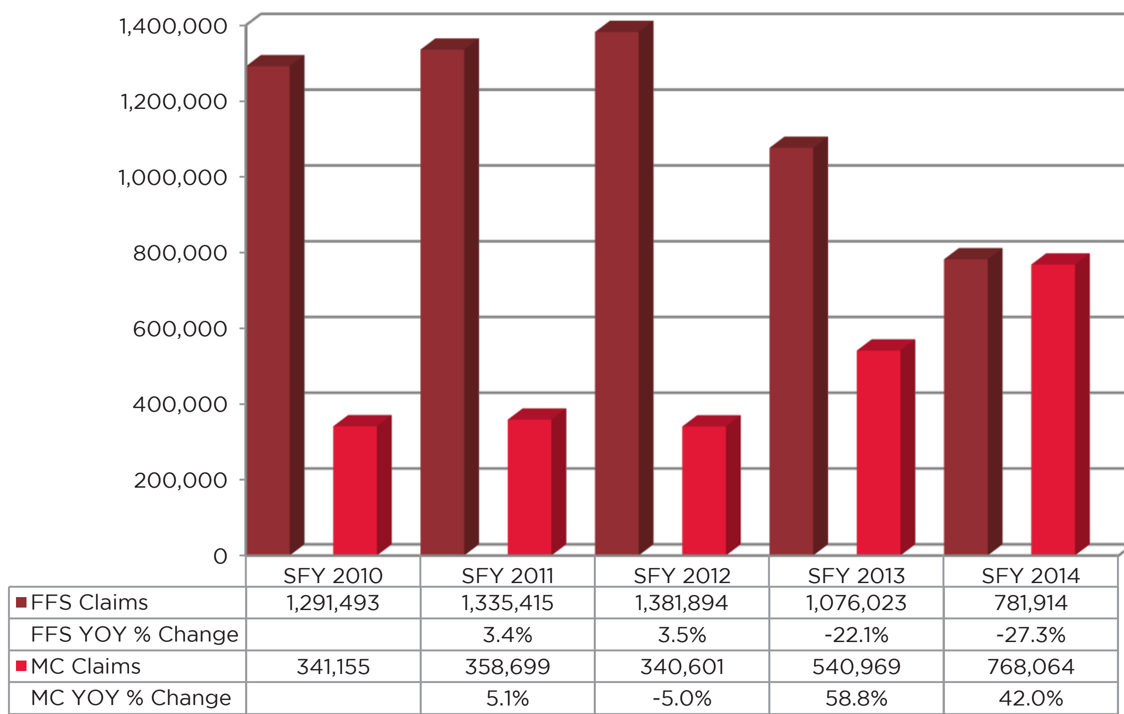
FIGURE 19

PHYSICIAN SERVICES

Medicaid pays for each Medicaid eligible to see a primary care provider (PCP) when the member is having health concerns. Most of the time treatment can be provided by the PCP in the office. If the PCP feels the problem is too serious to treat in the office, a referral is made to a specialist.

Figure 20 displays a statewide look at the number of claims of Medicaid members who have utilized physician services. The decline in the number of FFS claims in FY 2013 and FY 2014 were offset by the increase in the number of managed care claims in both years. The shift in claims between FFS and managed care is attributable to the establishment of ACOs during SFY 2013.

Unduplicated Physician Services Claims

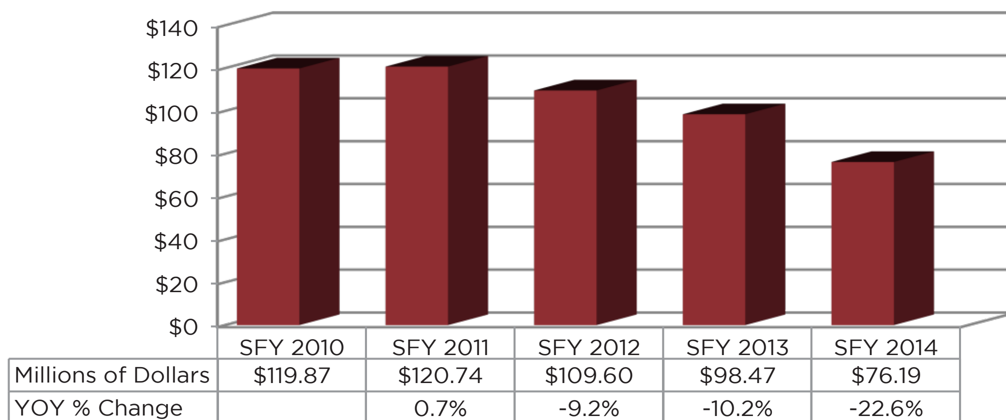


	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
FFS Claims	1,291,493	1,335,415	1,381,894	1,076,023	781,914
FFS YOY % Change		3.4%	3.5%	-22.1%	-27.3%
MC Claims	341,155	358,699	340,601	540,969	768,064
MC YOY % Change		5.1%	-5.0%	58.8%	42.0%

FIGURE 20

Figure 21 provides a look at statewide FFS physician services associated expenditures. The decline in SFY 2013 and again in SFY 2014 is largely attributable to the establishment of ACOs. Furthermore, given that managed care expenditures are capitated, they are not included in figure 21.

FFS Physician Services Expenditures



	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Millions of Dollars	$119.87	$120.74	$109.60	$98.47	$76.19
YOY % Change		0.7%	-9.2%	-10.2%	-22.6%

FIGURE 21

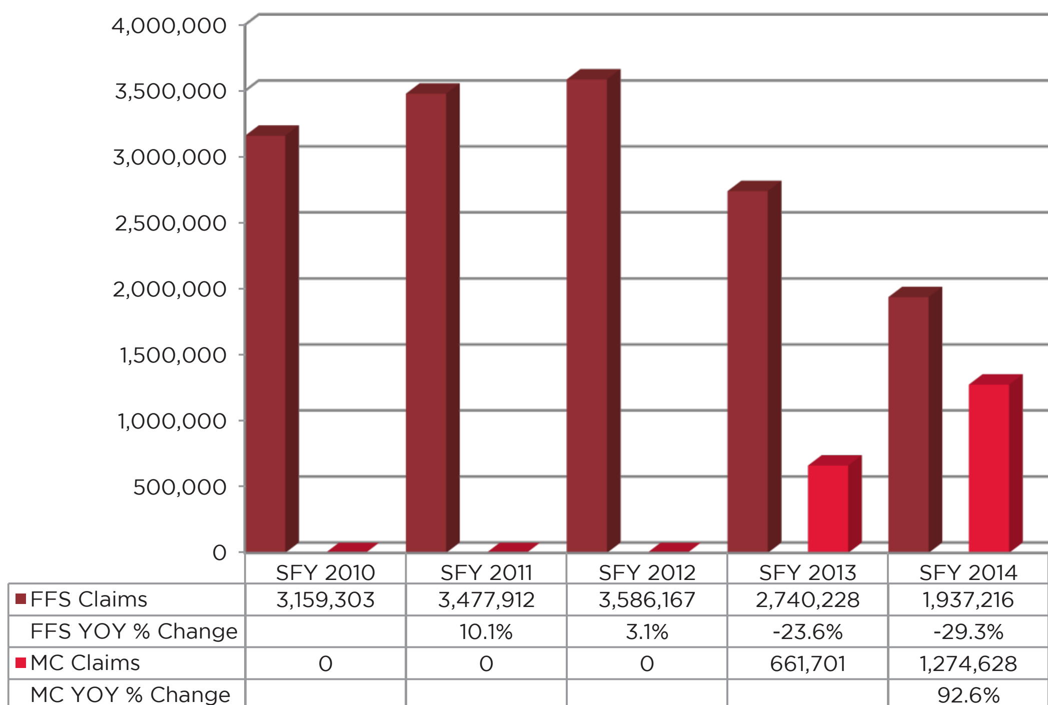
PHARMACY SERVICES

DMHF provides coverage for nearly all available prescription drugs approved by the Food and Drug Administration (FDA).

To manage the costs of prescription drugs, DMHF has a generic-first requirement. If a generic product is available in a drug class and it is not more expensive than the brand name product, then the pharmacy must dispense the generic. If a generic brand for the drug does not exist, then a name brand is often used. Some prescriptions require prior approval.

DMHF also employs a Preferred Drug List (PDL) program with prior authorization. Following a determination of safety and efficacy by the Pharmacy and Therapeutics Committee, preferred drugs are selected based upon recommendations by the Committee and the net cost of the drugs. In many cases, the manufacturers of these products provide a secondary rebate to Medicaid.

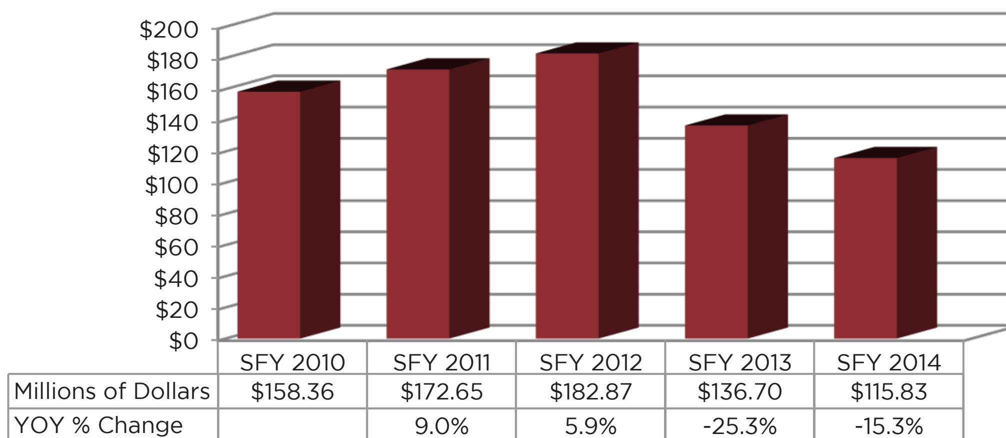
Figure 22 shows the number FFS and managed care claims of Medicaid members utilizing pharmacy services. The decline in the number of FFS claims in SFY 2013 and SFY 2014 were offset by the increase in the number of managed care claims in both years. The shift in claim counts between FFS and managed care is attributable to the establishment of the ACO model during SFY 2013.



	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
FFS Claims	3,159,303	3,477,912	3,586,167	2,740,228	1,937,216
FFS YOY % Change		10.1%	3.1%	-23.6%	-29.3%
MC Claims	0	0	0	661,701	1,274,628
MC YOY % Change					92.6%

FIGURE 22

Figure 23 illustrates statewide expenditures on FFS pharmacy services. The decline in SFY 2013 and again in SFY 2014 is largely due to the implementation of the ACO model during. Managed care expenditures are not included in figure 23 since these expenditures are capitated.

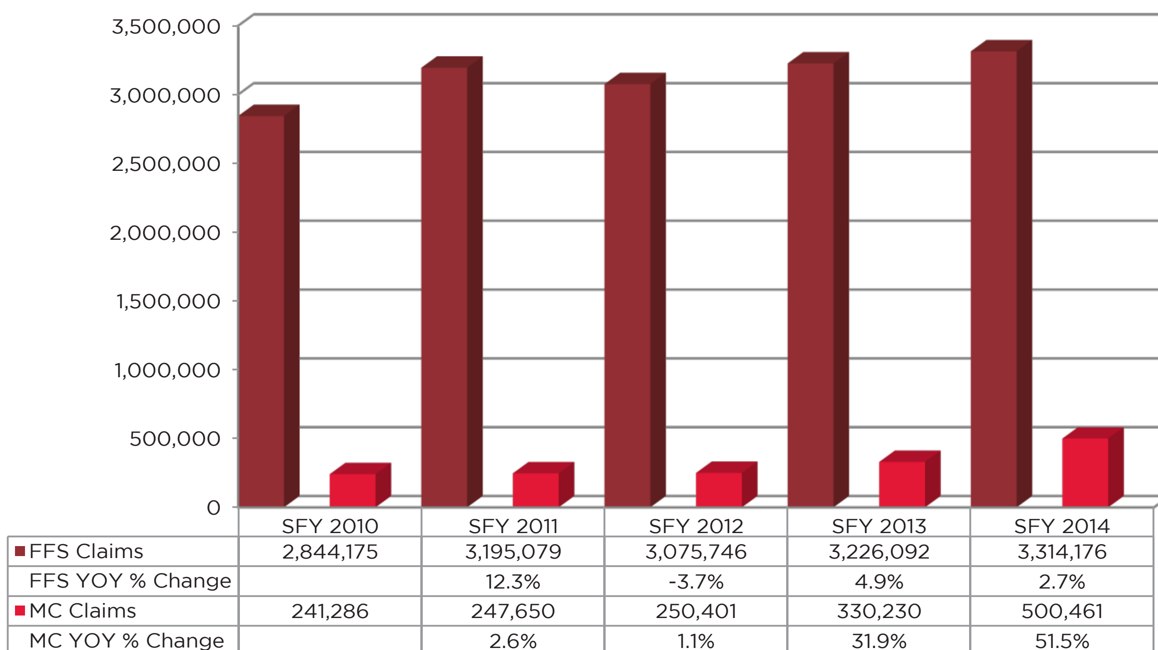


	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Millions of Dollars	$158.36	$172.65	$182.87	$136.70	$115.83
YOY % Change		9.0%	5.9%	-25.3%	-15.3%

FIGURE 23

OTHER SERVICES

Figure 24 illustrates the number of claims of Medicaid members utilizing all other services. The "other" group includes services provided via medical and non-medical transportation, home health services/hospices, dental facilities, vision care, occupational therapists, rural health facilities, physical therapists, podiatrists, chiropractors, nutritionists and psychologists.



	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
FFS Claims	2,844,175	3,195,079	3,075,746	3,226,092	3,314,176
FFS YOY % Change		12.3%	-3.7%	4.9%	2.7%
MC Claims	241,286	247,650	250,401	330,230	500,461
MC YOY % Change		2.6%	1.1%	31.9%	51.5%

FIGURE 24

Figure 25 depicts statewide expenditures on the other services category. Managed care expenditures are not included in Figure 25 given that they are capitated.

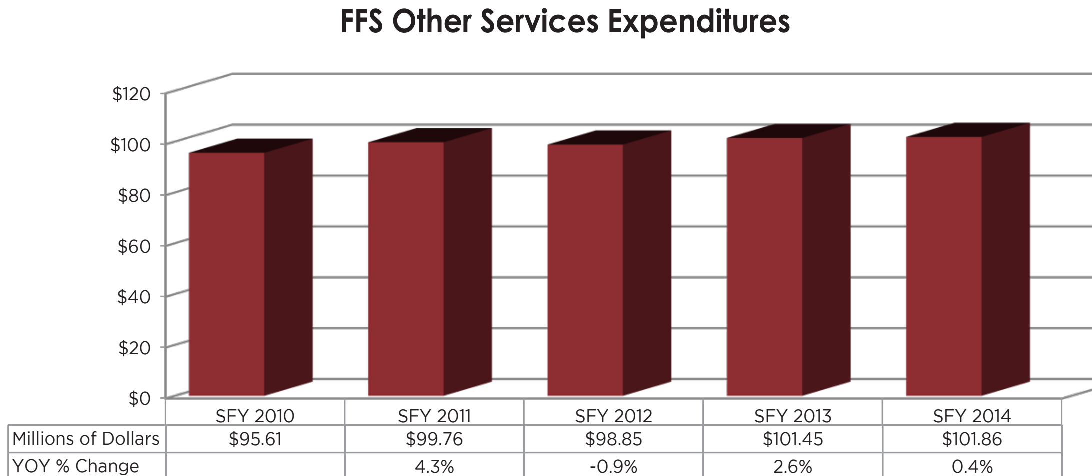


FIGURE 25

Long-Term Care

Long-term care (LTC) includes a variety of services that help meet the needs of individuals with chronic illnesses or disabilities. Long-term care services can be provided in homes and community-based (HCBS) settings or nursing facilities. Eligibility for receiving long-term care services is dependent on assessments performed to determine whether the level-of-care provided in the long-term care program is essential. Individuals are re-assessed periodically, either annually or other routinely scheduled basis, to assess the need for continued LTC services.

Figure 26 illustrates statewide LTC related expenditures.

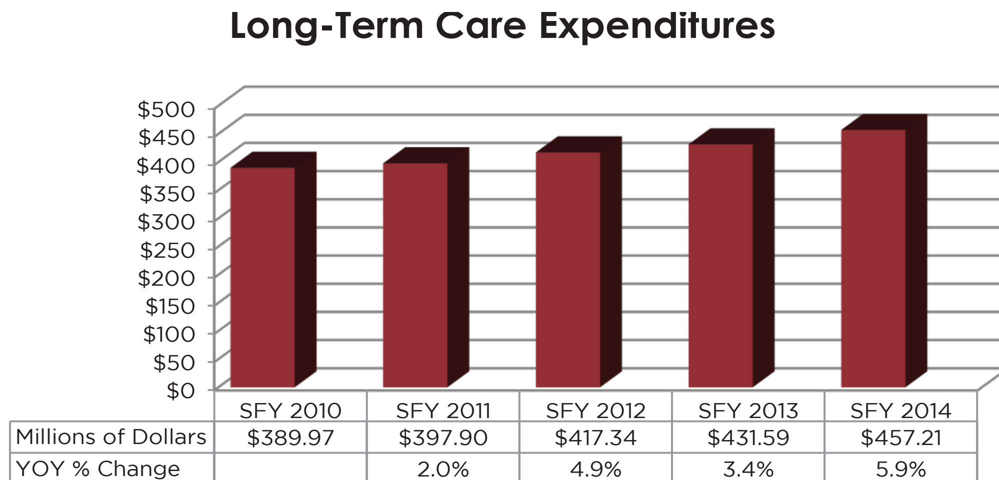


FIGURE 26

Table 20 provides a county level detail of long-term care expenditures. Expenditures for these services declined in nine counties between SFY 2013 and SFY 2014, most of which were non-Wasatch Front counties.

Table 20: Long-Term Care Expenditures by County					
County	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
BEAVER	$1,159,000	$1,009,200	$1,098,700	$968,300	$972,100
BOX ELDER	$5,725,700	$5,484,400	$5,956,600	$5,903,700	$5,585,100
CACHE	$13,829,600	$14,027,200	$13,813,400	$13,756,500	$13,676,900
CARBON	$7,361,900	$5,545,000	$6,082,100	$6,471,000	$6,297,800
DAGGETT	$31,400	$33,000	$0	$0	$0
DAVIS	$30,852,200	$31,990,100	$34,808,600	$36,283,300	$37,474,300
DUCHESNE	$3,490,200	$3,556,700	$4,224,800	$3,669,700	$3,652,000
EMERY	$1,404,500	$1,294,900	$1,560,600	$1,577,700	$2,087,500
GARFIELD	$1,020,100	$1,053,300	$971,900	$959,300	$820,100
GRAND	$711,200	$784,600	$1,311,600	$1,140,300	$1,958,900
IRON	$7,263,300	$7,396,000	$7,922,400	$8,317,000	$8,861,100
JUAB	$2,830,100	$2,653,800	$2,694,200	$2,966,900	$3,191,100
KANE	$774,200	$740,600	$696,000	$607,300	$595,300
MILLARD	$1,914,200	$2,269,600	$2,152,300	$1,819,300	$1,869,600
MORGAN	$94,500	$120,600	$145,700	$218,500	$250,600
PIUTE	$37,200	$123,200	$110,200	$51,100	$118,600
RICH	$118,800	$71,700	$87,800	$124,800	$56,600
SALT LAKE	$133,566,100	$138,689,000	$145,277,000	$148,291,100	$152,634,500
SAN JUAN	$3,966,600	$4,068,400	$4,088,700	$3,893,500	$4,532,100
SANPETE	$3,001,600	$2,794,100	$2,824,700	$2,921,000	$2,990,100
SEVIER	$3,046,800	$3,254,100	$4,126,100	$4,192,700	$4,035,900
SUMMIT	$817,400	$795,700	$776,700	$972,300	$1,416,900
TOOELE	$3,551,800	$3,201,700	$3,136,800	$3,838,600	$4,161,500
UINTAH	$4,833,200	$5,012,000	$5,083,400	$5,456,300	$7,933,900
UTAH	$86,622,600	$87,339,100	$89,874,800	$91,623,400	$95,707,600
WASATCH	$1,928,500	$1,959,000	$1,814,000	$1,845,100	$2,072,300
WASHINGTON	$15,721,100	$16,675,800	$17,080,200	$17,331,500	$17,601,500
WAYNE	$55,300	$40,400	$70,000	$23,800	$79,600
WEBER	$35,169,900	$33,921,200	$34,738,400	$36,754,200	$34,996,100
Long-Term Care Total	**$370,899,000**	**$375,904,400**	**$392,527,700**	**$401,978,200**	**$415,629,600**

LONG-TERM CARE: NURSING HOME SERVICES

Nursing home services provide a full array of care on a 24-hour basis in licensed, skilled or intermediate care facilities including specialized facilities for people with intellectual disabilities. Services provided in the various facilities include: medical treatment to residents whose medical conditions are unstable and/or complex; medical treatment to residents whose medical conditions are stable but still require nursing care; supervision and assistance with daily living activities such as bathing, dressing and eating; and active treatment and health-related services to residents with intellectual disabilities in a supervised environment.

Table 21 provides nursing home expenditures for the Wasatch Front (Davis, Salt Lake, Utah and Weber Counties) and non-Wasatch Front Counties.

Table 21: Nursing Home Expenditures by Locality					
	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
DAVIS	$17,795,500	$17,733,400	$19,545,900	$20,008,800	$20,888,600
SALT LAKE	$69,741,400	$75,010,700	$80,224,600	$78,576,400	$82,994,100
UTAH	$58,326,800	$59,688,900	$60,810,700	$60,960,100	$64,911,000
WEBER	$21,930,200	$21,395,000	$22,264,500	$24,015,400	$22,207,000
All Other Counties	$45,376,200	$44,314,000	$45,436,100	$42,935,900	$47,929,700
Total	**$213,170,100**	**$218,142,000**	**$228,281,800**	**$226,496,600**	**$238,930,400**

LONG-TERM CARE: HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS

The State operates seven HCBS waivers. HCBS waivers provide LTC services in home and community-based settings as an alternative to nursing home services or services provided in an intermediate care facility for individuals with intellectual disabilities. The day-to-day administration and state funding of four of the HCBS waivers is provided by the Department of Human Services (DHS): 1) Waiver for Individuals Aged 65 and Older, 2) Waiver for Individuals with Acquired Brain Injuries, 3) Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions, and 4) the Waiver for Individuals with Physical Disabilities. The New Choices Waiver and Technology Dependent Waiver are managed internally and funded through DMHF. The Medicaid Autism Waiver is funded through DMHF and the day-to-day operations are managed by DHS. DMHF retains final administrative oversight of the HCBS waivers in its role as the Single State Agency.

Waiver for Individuals Aged 65 and Older (Aging Waiver) – This program's primary focus is to provide services to elderly individuals in their own homes or the home of a loved one. This program seeks to prevent or delay the need for nursing home care. DHS Division of Aging and Adult Services oversees the day-to-day operation and provides the state funding for this program.

Waiver for Individuals with Acquired Brain Injuries – This program's primary focus is to provide services to adults who have sustained acquired brain injuries. Services are provided in an individual's own home, or for those with more complex needs, in a residential setting. This program seeks to prevent or delay the need for nursing home care. DHS Division of Services for People with Disabilities oversees the day-to-day operation and provides the state funding of this program.

Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions
This program's primary focus is to provide services to children and adults with intellectual disabilities. Services are provided in an individual's own home, or for those with more complex needs, in a residential setting. This program seeks to prevent or delay the need for services provided in an intermediate care facility for people with intellectual disabilities (ICF/ID). DHS Division of Services for People with Disabilities oversees the day-to-day operation and provides the state funding of this program.

Waiver for Individuals with Physical Disabilities – This program's primary focus is to provide services to adults who have physical disabilities. Services are provided in an individual's own home or the home of a loved one. This program seeks to prevent or delay the need for nursing home care. DHS Division of Services for People with Disabilities oversees the day-to-day operation and provides the state funding of this program.

Medicaid Autism Waiver Program – This program serves children with autism spectrum disorders, two through six years old. The primary service provided in this program is Applied Behavior Analysis (ABA). ABA involves teaching skills that facilitate development by breaking the skill into small parts and working on one sub-skill at a time until mastery is achieved. ABA services are provided primarily in the child's home. The DHS Division of Services for People with Disabilities oversees the day-to-day operations and the DMHF provides the state funding for the program.

New Choices Waiver – The purpose of this waiver is to assist individuals who are currently residing in nursing facilities or licensed assisted living facilities to have the option to receive community-based services in the setting of their choice rather than in a nursing facility. DMHF oversees the day-to-day operations and provides the state funding for this program.

Technology Dependent Waiver – This program permits the State to furnish an array of home and community-based services (in addition to Medicaid State Plan services) necessary to assist technology dependent individuals with complex medical needs, allowing them to live at home and avoid institutionalization. Responsibility for the day-to-day administration and operation of this waiver is shared by DMHF and the Division of Family Health and Prevention (also under the umbrella of the Single State Agency). DMHF provides the state matching funds for this program.

Figure 27 and Table 22 show the expenditures associated with Home and Community-Based Services (HCBS).

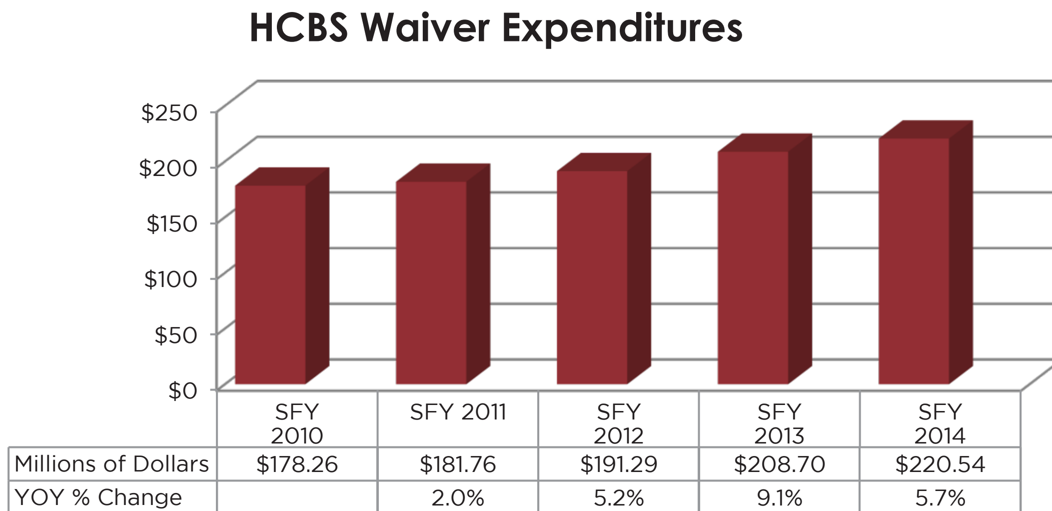


FIGURE 27

Table 22: HCBS Waiver Expenditures					
	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Acquired Brain Injury Waiver	$2,673,400	$2,642,600	$2,690,400	$3,406,200	$3,627,784
Aging Waiver	$3,489,900	$3,482,900	$4,142,300	$4,225,300	$4,052,901
Community Supports Waiver	$149,592,400	$149,681,700	$155,357,800	$165,675,900	$172,594,186
New Choices Waiver	$18,714,300	$21,688,900	$24,712,300	$29,570,900	$35,694,282
Physical Disabilities Waiver	$1,937,900	$1,889,900	$1,959,200	$2,125,100	$2,194,571
Tech Dependent Waiver	$1,856,200	$2,378,000	$2,425,200	$2,768,100	$3,050,108
Autism Waiver	$0	$0	$0	$929,700	$5,380,124
Grand Total	**$178,264,100**	**$181,764,000**	**$191,287,200**	**$208,701,200**	**$226,593,955**

Table 23 shows long-term care expenditures by institutional and non-institutional settings. Institutional costs include nursing facility and ICF/ID expenditures. Non-Institutional costs include home and community based waivers, personal care, private duty nursing, and home health expenditures.

Table 23: Long-Term Care Institutional and Non-Institutional Expenditure Comparison						
State Fiscal Year	Institutional Total Costs	Non-Institutional Total Costs	Total Combined Costs	Difference between Non-Institutional and Institutional Total	Institutional Percentage of Total Costs	Non-Institutional Percentage of Total Costs
SFY 2010	$59,391,400	$57,865,400	$117,256,800	($1,526,000)	50.7%	49.3%
SFY 2011	$61,811,300	$63,354,800	$125,166,100	$1,543,500	49.4%	50.6%
SFY 2012	$64,589,300	$64,434,500	$129,023,800	($154,800)	50.1%	49.9%
SFY 2013	$66,530,100	$71,795,400	$138,325,500	$5,265,300	48.1%	51.9%
SFY 2014	$67,754,200	$69,325,600	$137,079,800	$1,571,400	49.4%	50.6%

Means of Finance

The Utah Department of Health (DOH) manages the Children's Health Insurance Program (CHIP) through the Division of Medicaid and Health Financing (DMHF). All eligibility actions are contracted to the Department of Workforce Services (DWS).

CHIP is a state-sponsored health insurance plan for uninsured children from households up to 200 percent of the of the federal poverty level (FPL). In 2014, a family of four with an income of $47,700 or less would qualify (see Appendix A).

In accordance with Section 26-40-106, Utah Code Annotated, CHIP benefits for state fiscal year (SFY) 2014 were actuarially equivalent to the benefits received by enrollees in Select Health's Small Business Account plan; the commercial plan with the largest enrollment in the state. In SFY 2014, CHIP contracted with two managed care plans to provide medical services: Molina Healthcare of Utah and SelectHealth.

CHIP contracted with two dental providers, Premier Access and DentaQuest, to provide dental services for all CHIP enrollees. Premier Access is available statewide, while DentaQuest is available in Salt Lake, Weber, Davis, and Utah counties.

CHIP receives approximately 80 percent of its funding from the federal government under Title XXI of the Social Security Act with the other 20 percent coming from state matching funds. From SFY 2001 to SFY 2007, state funds came exclusively from the proceeds of the Master Settlement Agreement between the State and Tobacco companies. In SFY 2008 to SFY 2014, the state funding also included an appropriation from the General Fund.

- For SFY 2010, the Legislature decreased the ongoing General Fund to $0.5 million and increased the Tobacco Settlement Restricted Fund to $14.1 million to cover the loss in the General Fund. The program also had $2.9 million carried forward from SFY 2009.
- For SFY 2011, the Legislature appropriated an additional $2.4 million of one-time General Fund dollars for a total of $2.9 million. This appropriation was due to a shortfall in the Tobacco Settlement Restricted Fund. The Tobacco Settlement Restricted Fund appropriation was reduced to $11.7 million. The program was not allowed to carry forward the $2.9 million from SFY 2009. However, the program was allowed to carry forward $0.6 million into SFY 2012 through non-lapsing authority.
- For SFY 2012, the Legislature appropriated an additional $3.0 million of one-time General Fund dollars for a total of $4.9 million. This appropriation was due to a shortfall in the Tobacco Settlement Restricted Fund. The Tobacco Settlement Restricted Fund appropriation was reduced to $11.1 million. The program was allowed to carry forward the $0.6 million from SFY 2011. The program was also allowed to carry forward $2.9 million into SFY 2013 through non-lapsing authority.
- For SFY 2013, the Legislature appropriated $5.4 million in General Fund and $11.5 million in Tobacco Cost Settlement Restricted Fund. In addition, the program had General Fund carried forward from SFY 2012 of $2.9 million. The program was also allowed to carry forward $1.4 million into SFY 2014 through non-lapsing authority.
- For SFY 2014, the Legislature appropriated $2.8 million in General Fund and $11.5 million in Tobacco Cost Settlement Restricted Fund. In addition, the program had General Fund carried forward from SFY 2013 of $1.4 million. The program was also allowed to carry forward $1.4 million into SFY 2015 through non-lapsing authority.

Cost Sharing Benefits

Families pay a premium of up to $75 per quarter for enrollment in CHIP. The amount of premium varies depending upon a family's income. There is also a $15 late fee if families fail to pay their premiums on time. American Indian and Alaska Native families and families with incomes below 100 percent FPL do not pay quarterly premiums. In SFY 2014, CHIP collected $1.8 million in premiums and late fees. Premiums are used to fund the CHIP program and are appropriated as dedicated credits in the annual CHIP budget.

Most CHIP families pay co-payments in addition to their quarterly premiums. Native American families are not required to make co-payments. As established in federal regulations, a family on CHIP is not required to spend more than five percent of their family's annual gross income on premiums, co-payments and other out-of pocket costs combined during their eligibility certification period.

Federal guidelines allow states to select from several options in creating a benchmark for CHIP coverage. As of July 1, 2008, CHIP moved to a commercial health plan benefit for its benchmark. In addition, as of July 1, 2010, CHIP adopted the commercial dental plan for its dental benchmark.

Major Budget Categories

MEDICAL

CHIP contracts with two different managed care organizations. Both health plans are full risk plans, offering a comprehensive medical coverage plan with CHIP funds paying the cost of a monthly capitated rate.

DENTAL

CHIP utilizes two dental plans to manage the dental program. Both dental plans are risk-based with CHIP funds paying a monthly capitated rate for dental coverage.

UTAH'S PREMIUM PARTNERSHIP FOR HEALTH INSURANCE (UPP)

UPP is an effort to offer families premium assistance when they enroll their children in their employer-sponsored health plan rather than CHIP. The current rebate is up to $120 per child per month for medical coverage and an additional $20 per month for dental coverage.

CHIP Expenditures

Table 24 shows CHIP expenditures in SFY 2014. Between SFY 2013 and SFY 2014, total CHIP expenditures increased by 1.3 percent

Table 24: CHIP Expenditures SFY 2014		
Service Expenditures	**TOTAL**	**Percent of Total**
Capitated Managed Health Care		
SelectHealth	$27,298,200	37.0%
Molina	$14,215,100	19.3%
Dental Services		
Premier Access	$6,347,100	8.6%
DentaQuest	$1,225,600	1.7%
Immunization Services	$1,818,700	2.5%
Other Services	$1,064,800	1.4%
CHIP-I-CAID Transfer	$15,978,400	21.7%
Total CHIP Services	**$67,947,900**	**92.2%**
UPP Services	$404,500	0.5%
Total Service Expenditures	**$68,352,400**	**92.7%**
Administrative Expenditures		
DOH	$2,915,200	4.0%
DWS	$2,458,200	3.3%
Total Administrative Expenditures	**$5,373,400**	**7.3%**
TOTAL	**$73,725,800**	**100.0%**

See Table 1 at the beginning of the report for a five year history of CHIP expenditures.

CHIP-I-CAID is the term used by DMHF to describe the transfer of costs from Medicaid to CHIP for the children that moved from CHIP to Medicaid in early 2014 as a result of the ACA changes to income and asset eligibility guidelines for children.

Utah's Premium Partnership for Health Insurance (UPP)

In an effort to create private health insurance opportunities for individuals that qualify for CHIP, DOH obtained federal approval to offer families the ability to purchase their employer-sponsored health insurance rather than enroll their children in CHIP. Beginning in November 2006, qualified families were eligible to receive a rebate when they purchased health coverage through their work. In addition, qualified families also receive an additional rebate if they purchased dental coverage through their work.

In December 2009, UPP was given approval by CMS to help low-income individuals and families pay for their COBRA coverage. Families that are either COBRA eligible or who are already enrolled in COBRA may also qualify to receive up to $150 per adult each month and up to $140 per child each month to help subsidize their monthly COBRA premium payment.

On March 24, 2010, the President of the United States issued an Executive Order that clarified how rules limiting the use of federal funds for abortion services would be applied to the new health insurance exchanges. DOH determined that the Executive Order in conjunction with the intent of state law regarding the use of public funds for abortion created new expectations in regards to the UPP subsidy. An emergency rule, effective April 1, 2010, was filed to prohibit UPP from reimbursing families that were enrolled in plans covering abortion services beyond the circumstances allowed for the use of federal funds (i.e., life of the mother, rape, or incest). In order to be eligible for UPP, the insurance plan the family wishes to enroll in must meet the definition of "creditable coverage" as defined in Utah Administrative Code.

In September 2012, CMS approved raising UPP's income eligibility level for adults to 200 percent FPL. The levels are now the same for adults and children on UPP.

Eligibility Requirements and the Enrollment Process

Per Utah Code 26-40-105, CHIP is required to keep enrollment continuously open. Applications for CHIP can be submitted through the mail, in-person, and online.

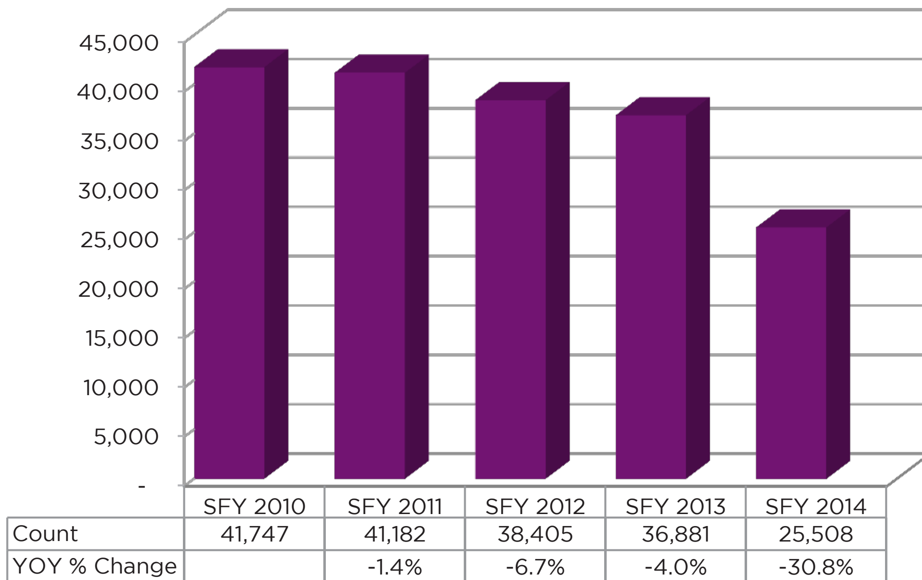
Basic eligibility criteria:

1. Gross family income cannot be higher than 200 percent FPL (for a family of four, 200 percent FPL is $47,700).
2. The child must be a resident of the state of Utah, and a U.S. citizen or legal alien.
3. The child must be 18 years of age or younger.
4. The child must be uninsured and not eligible for Medicaid.

Enrollment Statistics

Figure 28 shows the unduplicated count of CHIP and UPP enrollment between SFY 2010 and SFY 2014. The large drop between SFY 2013 and SFY 2014 is mostly attributable to ACA requirements. Many children who were on CHIP were required to move to Medicaid when the ACA removed the asset test and increased the required income level on January 1, 2014.

CHIP Enrollment



	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Count	41,747	41,182	38,405	36,881	25,508
YOY % Change		-1.4%	-6.7%	-4.0%	-30.8%

FIGURE 28

Figure 29 breaks out CHIP enrollment by FPL. Please note, UPP enrollment is not included in this chart.

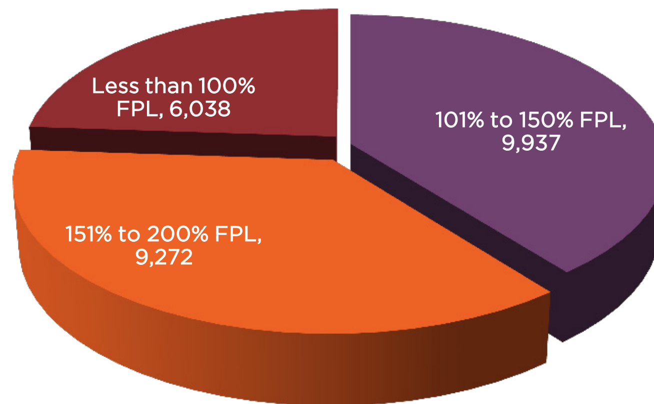


FIGURE 29

Table 25 shows that sixty-nine percent of CHIP and UPP children reside in the Wasatch Front (Davis, Salt Lake, Weber, and Utah counties). Thirty-one percent reside in the remaining 25 counties.

Table 25: Unduplicated CHIP Enrollment by Location and FPL

Location	Federal Poverty Guidelines	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Non-Wasatch Front	101% to 150% FPL	5,280	4,679	4,435	4,215	2,864
	151% to 200% FPL	3,488	2,923	2,652	2,530	2,731
	Less than 100% FPL	4,899	5,476	4,972	4,495	1,954
	UPP	151	106	73	56	72
Non-Wasatch Front Total		13,818	13,184	12,132	11,296	7,620
Wasatch Front	101% to 150% FPL	10,917	10,325	10,003	10,034	7,073
	151% to 200% FPL	7,444	6,442	5,929	5,909	6,541
	Less than 100% FPL	9,199	10,915	10,078	9,421	4,084
	UPP	369	316	263	221	190
Wasatch Front Total		27,929	27,998	26,273	25,585	17,888
Grand Total		**41,747**	**41,182**	**38,405**	**36,881**	**25,508**

Figure 30 shows the urban and rural percentages of enrollment between SFY 2010 and SFY 2014.

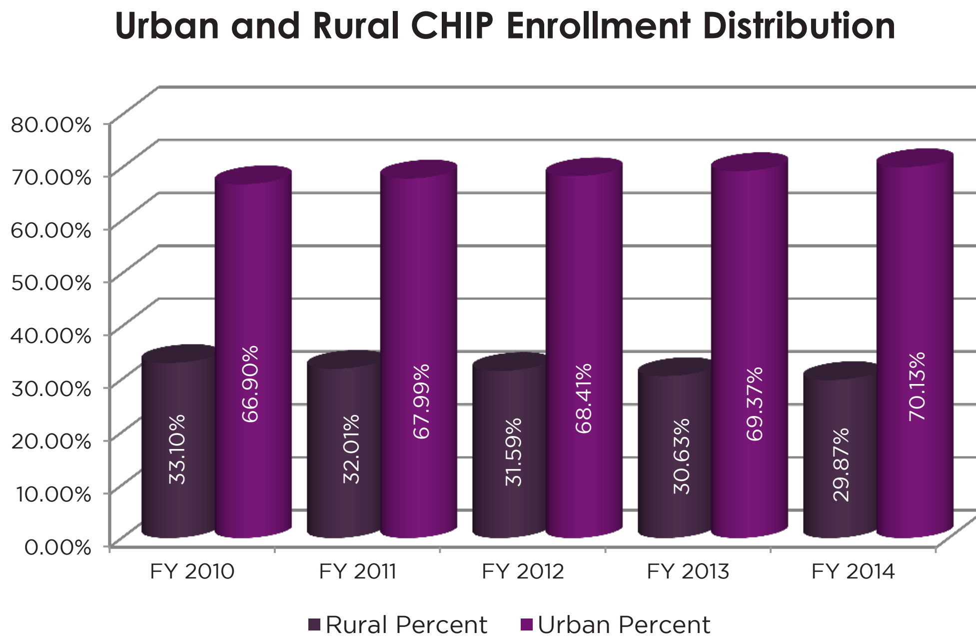


FIGURE 30

Figure 31 shows how CHIP enrollment is distributed by age range.

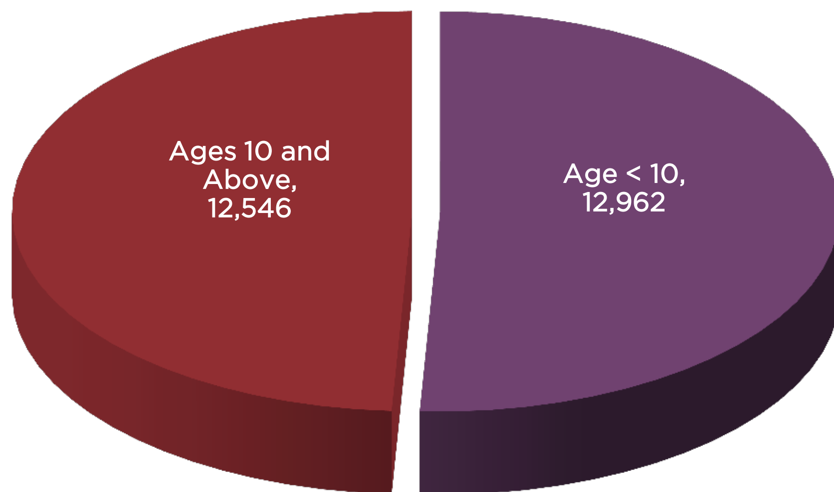


FIGURE 31

Figure 32 illustrates CHIP enrollment distribution by race.

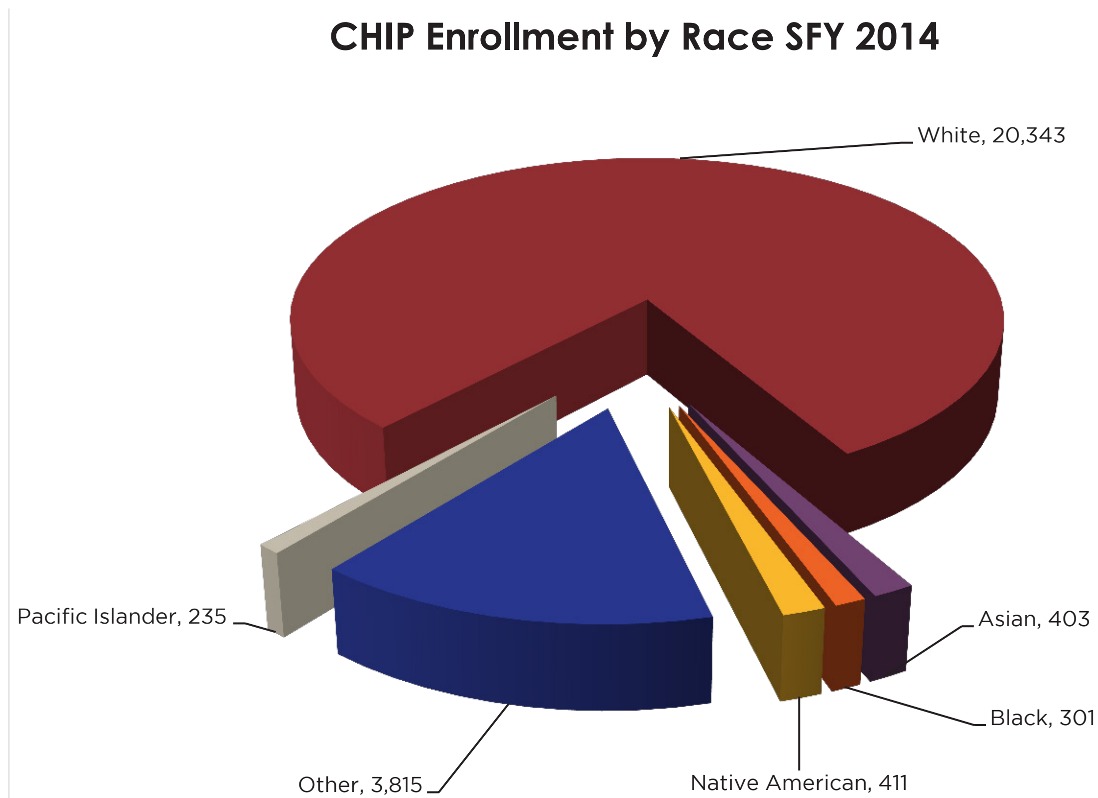


FIGURE 32

Table 26 presents CHIP enrollment by age and race.

Table 26: CHIP Enrollment by Age Range and Race						
Age Range	Race	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Age < 10	Asian	324	290	250	220	170
	Black	271	273	201	176	112
	Native American	282	272	208	200	170
	Other	15	461	1,675	2,631	2,868
	Pacific Islander	236	256	198	145	106
	White	21,044	19,278	16,211	14,383	9,536
Age < 10 Total		22,172	20,830	18,743	17,755	12,962
Ages 10 And Above	Asian	359	397	377	338	234
	Black	260	266	267	248	190
	Native American	371	385	345	320	240
	Other	21	269	1,021	1,415	948
	Pacific Islander	180	239	217	175	124
	White	18,384	18,796	17,435	16,630	10,810
Ages 10 And Above Total		19,575	20,352	19,662	19,126	12,546
Grand Total		**41,747**	**41,182**	**38,405**	**36,881**	**25,508**

CHIP Benefits

MEDICAL

CHIP provides a comprehensive insurance which covers the following medical benefits:

- Well-child exams
- Immunizations
- Doctor visits
- Specialist visits
- Medical emergency services
- Ambulance
- Urgent care
- Ambulatory surgical
- Inpatient and outpatient hospital services
- Lab and x-rays
- Prescriptions
- Hearing and vision screening exams
- Mental health services

DENTAL

CHIP provides the following benefits up to an annual maximum of $1,000:

- Preventive services
- Fillings
- Extractions
- Oral surgery
- Crowns
- Bridges
- Dentures
- Endodontics
- Periodontics
- Orthodontics

Table A cross references household size with the percent of Federal Poverty Levels and corresponding annual income. The Federal Poverty Level percentages are set by the United States Department of Health and Human Services.

Table A: 2014 HHS Poverty Levels				
Persons in family/household	100% FPL	133% FPL	150% FPL	200% FPL
1	$11,670	$15,521	$17,505	$23,340
2	$15,730	$20,921	$23,595	$31,460
3	$19,790	$26,321	$29,685	$39,580
4	$23,850	$31,721	$35,775	$47,700
5	$27,910	$37,120	$41,865	$55,820
6	$31,970	$42,520	$47,955	$63,940
7	$36,030	$47,920	$54,045	$72,060
8	$40,090	$53,320	$60,135	$80,180
For each additional person, add:	$4,060	$5,400	$6,090	$8,120

Figure A summarizes income requirements for many of the Medicaid programs and CHIP. As shown in the eligibility chart, maximum income levels exist for different groupings. Although most eligibility categories allow access to the full array of Medicaid services, there are economic and medical circumstances that assign enrollees to limited sets of benefits. For example, a pregnant woman may be eligible for medical assistance if her annual income is less than or equal to 133 percent of the Federal Poverty Level (FPL). A child eligible for CHIP will have a different level of cost sharing if the family income is less than 150 percent FPL than a CHIP eligible child from a family with income between 150 percent and 200 percent FPL.

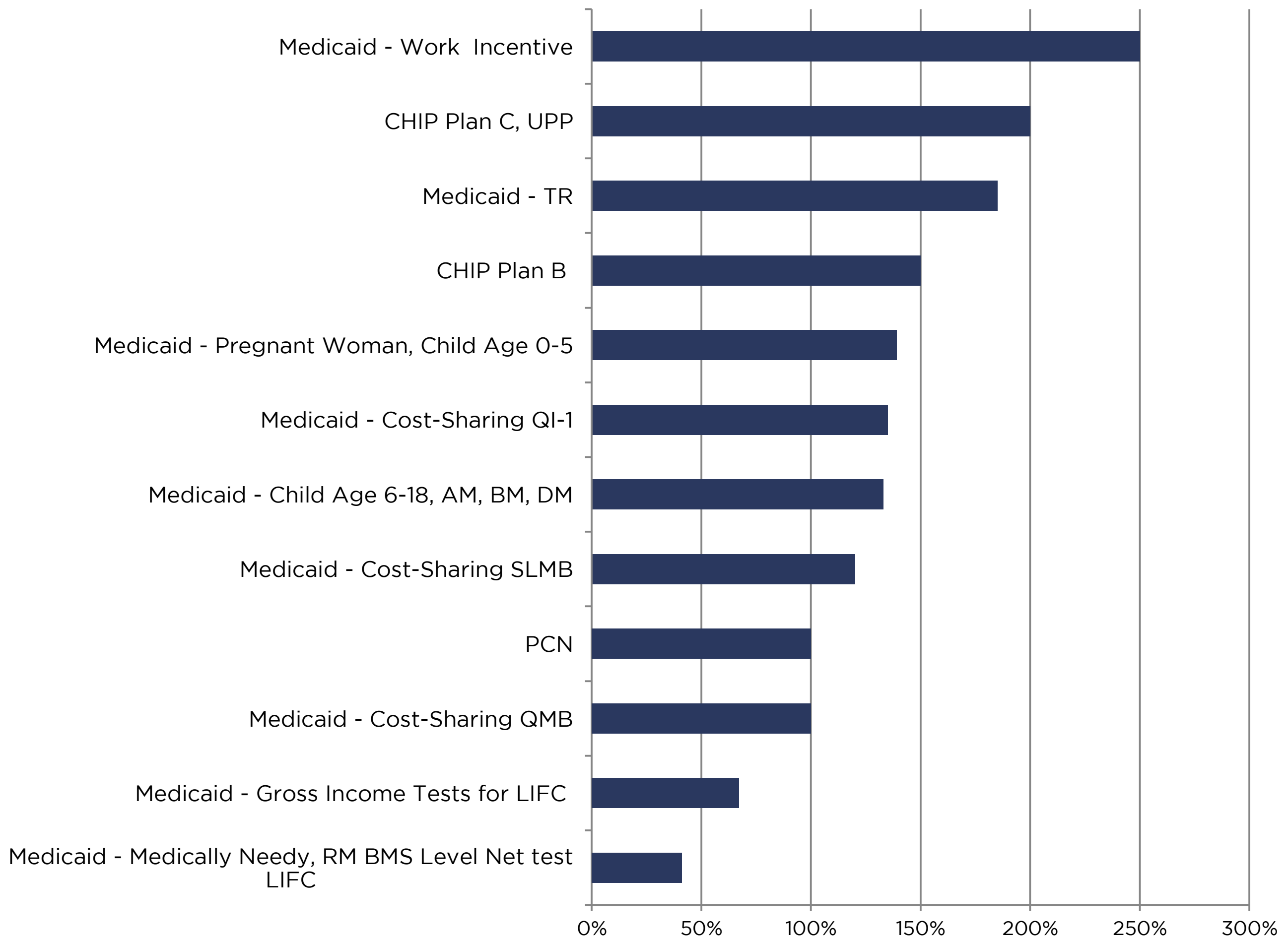


FIGURE A

Table B contains poverty level comparison between the United States, as a whole, and the state of Utah. The percent of Utah's population is lower than the nation's percentage for each level of poverty.

Table B: Poverty Level Comparisons Between Utah and the United States		
Poverty Level	U.S.	Utah
Below 100% Poverty	15.10%	10.00%
101% - 125% of Poverty	19.80%	13.80%
126% - 135% of Poverty	21.60%	15.90%
136% - 150% of Poverty	24.60%	18.60%
150% - 185% of Poverty	31.30%	26.00%
186% - 200% of Poverty	33.90%	28.50%

Source: United States' Census Bureau http://www.census.gov/

TITLE XIX - MEDICAID	Title XIX of the Social Security Act requires states to establish Medicaid programs to provide medical assistance to low income individuals and families. Within broad federal rules, each state decides eligible coverage groups, eligibility criteria, covered services, payment levels, and administrative and operating procedures.
TITLE XXI – STATE CHILDREN'S HEALTH INSURANCE PROGRAM	The purpose of Title XXI is to provide funding to assist states in providing medical coverage to uninsured, low income children in an effective manner.
AID CATEGORIES	A designation under which a person may be eligible for medical assistance.
ARREARS	The amount of money owed to a state or to a Non-IV-A participant that was not paid when due.
CAPITATION	A reimbursement method where the contractor is paid a fixed amount (premium) per enrollee per month.
CATEGORY OF ASSISTANCE	A group of aid categories consisting of clients with similar Medicaid eligibility. Examples include the Elderly, Visually Impaired and People with Disabilities.
CATEGORY OF SERVICE	A group of services that are provided by a common provider. Examples include Inpatient Hospital, Outpatient Hospital and Physician Services.
CHIP	The Children's Health Insurance Program is a state health insurance plan for children. Depending on income and family size, working Utah families who do not have other health insurance may qualify for CHIP.
CLAWBACK PAYMENTS	Federally required payments to the Medicare program that began in 2006 to cover the pharmacy needs of Medicare clients that were also eligible for Medicaid.
CMS	Centers for Medicare and Medicaid Services is a federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program.
DOH	Refers to the Utah Department of Health.
DHS	Refers to the Utah Department of Human Services.
DSH	Disproportionate Share payments made by the Medicaid program to hospitals designated as serving a disproportionate share of low-income or uninsured patients. DSH payments are in addition to regular Medicaid payments for providing care to Medicaid beneficiaries. The maximum amount of federal matching funds available annually to individual states for DSH payments is specified in the federal Medicaid statute.
DWS	Refers to the Utah Department of Workforce Services.
ELIGIBLE	An individual who is qualified to participate in the Utah State Medicaid or CHIP program but may or may not be enrolled.
ENROLLEE	An individual who is qualified to participate in Utah's Medicaid or CHIP program and whose application has been approved but he or she may or may not be receiving services.
FMAP	Federal Medical Assistance Percentage is the percentage the federal government will match for state money spent on Medicaid.
MANAGED HEALTH CARE	A system of health care organizations that contract with Medicaid to provide medical and mental health services to Medicaid clients.

MEDICAID RESTRICTED ACCOUNT	The General Fund Restricted Account created to hold any general funds appropriated to the DOH for the state plan for medical assistance or for the Division of Medicaid and Health Financing that are not expended in the fiscal year for which the general funds are appropriated and which are not designated as non-lapsing. Unused state funds associated with the Medicaid program from DWS and DHS and any penalties imposed or collected under various statutes shall be deposited. See UCA 26-18-402 for more detail.
NURSING CARE FACILITIES ACCOUNT	Proceeds from the assessment imposed by Section UCA 26-35a-104 which are deposited in a restricted account to be used for the purpose of obtaining federal financial participation in the Medicaid program.
PCN	Primary Care Network is a health plan for adults administered by DOH. It covers services administered by a primary care provider. Applications are accepted only during open enrollment periods.
PARTICIPATING PROVIDER	A provider who submitted a bill to Utah's Medicaid program for payment during the fiscal year.
PRESUMPTIVE ELIGIBILITY	Provides limited and temporary coverage for an enrollee whose eligibility is determined by a qualified provider prior to an agency determination of Medicaid eligibility.
RECIPIENTS (CLIENTS)	The unduplicated number of enrollees who had paid claim activity during a specific time period. This count is unduplicated by category of service as well as in total.
SEED	State funds appropriated to agencies outside the Division of Medicaid and Health Financing that are transferred to the DOH in order to draw down the federal match for Medicaid activities that occur within those other agencies.
SPENDDOWN MONEY	Clients that have too much income to qualify for Medicaid can spenddown their income if they have qualifying medical expenses that bring their net income to Medicaid levels.
STATE FISCAL YEAR (SFY)	The State Fiscal Year is a 12-month calendar that begins July 1 and ends June 30 of the following calendar year.
TANF	The federal block grant program Temporary Assistance for Needy Families, which succeeds the Aid to Families with Dependent Children program. In Utah, this program is known as the Family Employment Program (FEP).
TPL	Refers to Third Party Liability. Individuals or entities who have financial liability for medical costs of Medicaid recipients.
TRENDS	A measure of the rate at which the data is changing. Trends are calculated by the least squares method based on the past twelve months of date up to and including the current month.
UNDUPLICATED COUNT	Recipients who are counted only once regardless of whether they used one or more categories of service or are covered by one or more categories of assistance.
UNITS OF SERVICE	A measure of the medical service rendered to a client. The unit of measure of a service unit will vary with the type of claim. For example, the service unit for an inpatient hospital claim is days of stay, while the service unit for a dental claim is procedures.
WAIVER	The waiving of certain Medicaid statutory requirements which must be approved by CMS (see Appendix B).
WELFARE REFORM	New federal requirements as a result of the Personal Responsibility and Work Opportunities Reconciliation Act of 1996.

Waiver programs currently in effect in the state of Utah:

1115 WAIVER

Primary Care Network (PCN)

PCN is a health plan offering services from primary care providers. The federal government requires that more parents be enrolled than adults without dependent children. Since 2002, this waiver has enabled funding for Non-Traditional Medicaid, PCN, and Utah's Premium Partnership for Health Insurance (UPP). Funding for adults is through Title XIX (Medicaid). Children are funded through Title XXI (CHIP).

1915B WAIVERS

Choice of Health Care Delivery Program & Hemophilia Disease Management Program

This program grants operating authority to allow Medicaid to require Traditional Medicaid clients living in Davis, Salt Lake, Utah, and Weber counties to select a health plan that provides services in accordance with the program's waiver. In addition, this is the operating authority to allow Medicaid to contract with a Utah licensed pharmacy for the provision of anti-hemolytic factors to Utah's Medicaid clients with hemophilia.

Prepaid Mental Health Plan

This waiver allows Medicaid to mandatorily enroll most Title XIX recipients in 27 counties in this plan. Contracted mental health centers provide services covered under the waiver on an at-risk capitation basis.

Dental Choices Waiver

This waiver grants operating authority to allow Medicaid to require pregnant women and children enrolled in Traditional Medicaid living in Davis, Salt Lake, Utah, and Weber counties to select a dental managed care plan that provides Medicaid covered oral health services.

1915C WAIVERS

Technology Dependent, Medically Fragile

This program offers the choice of home and community-based alternatives for technology dependent, medically fragile individuals with complex medical conditions, who would otherwise require placement in a Medicaid enrolled nursing facility to obtain needed services (the costs of which would be borne by Medicaid). The waiver operates statewide, and serves a maximum of 130 recipients at any point in time.

This program permits the State to furnish an array of home and community-based services (in addition to Medicaid State Plan services) necessary to assist technology dependent individuals with complex medical needs to live at home and avoid institutionalization. Responsibility for the day-to-day administration and operation of this waiver is shared by the Division of Medicaid and Health Financing and the Division of Family Health and Prevention. The Division of Medicaid and Health Financing provides the State matching funds for this program.

Community Supports Waiver

This program serves over 4,600 individuals with intellectual disabilities in home and community-based setting as an alternative to institutional care in an Intermediate Care Facility for People with Intellectual Disabilities (ICF/ID).

This program's primary focus is to provide services to children and adults with intellectual disabilities. Services are provided in an individual's own home, or for those with more complex needs, in a residential setting. This

program seeks to prevent or delay the need for services provided in an ICF/ID. The Department of Human Services, Division of Services for People with Disabilities, provides for the day-to-day operation and the state funding of this program.

Aging Waiver

This program serves over 500 individuals over the age of 65 in home and community-based settings as an alternative to institutional care in a nursing facility.

This program's primary focus is to provide services to elderly individuals in their own homes or the home of a loved one. This program seeks to prevent or delay the need for nursing home care. The Department of Human Services, Division of Aging and Adult Services, provides for the day-to-day operation and the state funding of this program.

Acquired Brain Injury Waiver

This program serves approximately 110 individuals with acquired brain injuries in home and community-based settings as an alternative to institutional care in a nursing facility.

This program's primary focus is to provide services to adults who have sustained acquired brain injuries. Services are provided in an individual's own home, or for those with more complex needs, in a residential setting. This program seeks to prevent or delay the need for nursing home care. The Department of Human Services, Division of Services for People with Disabilities, provides for the day-to-day operation and the state funding of this program.

Physical Disabilities Waiver

This program serves approximately 130 individuals with physical disabilities in home and community-based settings as an alternative to institutional care in a nursing facility.

This program's primary focus is to provide services to adults who have physical disabilities. Services are provided in an individual's own home or the home of a loved one. This program seeks to prevent or delay the need for nursing home care. The Department of Human Services, Division of Services for People with Disabilities, provides for the day-to-day operation and the state funding of this program.

New Choices Waiver

This program is able to serve up to 1,700 people who were nursing facility residents or licensed assisted living facility residents immediately prior to enrolling in the waiver. The program provides services to these individuals in home and community-based settings as an alternative to institutional care in a nursing facility. Operation and administration of this waiver is completed by the Department of Health, Division of Medicaid and Health Financing.

The purpose of this waiver is to assist individuals to receive long term care services in a community-based setting rather than in a nursing facility.

Autism Waiver

This program serves over 300 children with autism spectrum disorders, 2 through 6 years old. The primary service provided in this program is Applied Behavior Analysis (ABA). ABA involves teaching skills that facilitate development by breaking the skill into small parts and working on one sub-skill at a time until mastery is achieved. ABA services are provided primarily in the child's home.

2014 Utah Annual Report of Medicaid & CHIP

UTAH DEPARTMENT OF HEALTH MEDICAID

A Bridge to Wellness for Utah's Vulnerable